STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014823	A. BUILDING: _____ B. WING _____	08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF SOUTH SHORE	2425 EAST 71ST STREET CHICAGO, IL 60649

(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
S 000	Initial Comments Annual Licensure Survey Complaint Investigation 2185440/IL136559 2185453/IL136572 2185713/IL136893	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 7) 300.610a) 300.1210b) 300.1210d)5) 300.1220b)3) 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 300.1210 General Requirements for Nursing and Personal Care	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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: 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as	S9999		

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S9999	Continued From page 2 are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to conduct a comprehensive skin assessment that includes a visual inspection of the resident's skin integrity after pressure is relieved to prevent new pressure ulcers from developing for 3 (R18, R10, R13) of 5 residents reviewed for pressure sores in the sample of 19 residents. These failures resulted in R18 acquiring a stage 3 pressure ulcer on inner buttocks and an unstageable wound on left heel, R13 developed a stage 3 pressure ulcer on coccyx, and R10 who was compromised with numerous pressure sores upon admission, developed a pressure wound on sacrum which was not assessed or treated by staff. Findings include: 1. R18 is an oriented, non-ambulatory 76 year old male who was admitted to the facility on 4/23/21 and discharged from the facility with return anticipated on 8/5/21. R19 was admitted with intact skin and for skilled rehabilitation due to a fall at home per the nursing admission note dated 4/23/21. R18 is incontinent of bowel and bladder per nurses' notes. On 8/11/21 at 11:29 AM, V41 (R18's daughter) stated that R18 was calling her complaining about much he was declining, and no one is helping	S9999		

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S9999	Continued From page 3 with exercises, getting up and out of bed and he is allowed to lay in urine and feces for long periods of time. V41 called the facility on 8/5/21and instructed the staff to send R18 to the hospital. On 8/12/21 at 10:48 AM, V34 (Physical Therapist) stated R18 was evaluated for skilled therapy on 4/24/21. V34 stated that R18 was assessed for the need of maximum assistance for bed mobility/rolling over in bed, and all other Activities of Daily Living (ADLs) required total assistance. V34 stated R18 was non-ambulatory and struggled to sit up at the bedside of the bed due to restriction in his hip range. V34 stated R18 was discharged from skilled therapy on 6/24/21 and at that time, R18 was moderate assist for transfers, contact guard for bed mobility and able to walk 10 feet on parallel bars with minimum assist. V34 stated R18 was then referred to restorative services. V34 stated that R18 returned to skilled therapy on 7/26/21 due to nurses' referral of significant decline in his ranges and ability. V34 stated when R18 returned to skilled therapy, R18 was maximum assist with bed mobility, total assist with ADLs, non-ambulatory and unable to sit at the bedside. On 8/11/21 at 11:53 AM, V15 (Wound Care Licensed Practical Nurse) stated R18 did have breakdown on his left heel and left inner buttocks, which were acquired in-house. V15 stated that pressure wounds are from failure to off load from a pressure area that is vulnerable to breakdown. V15 was instructed to bring physician documentation on why these wounds were unavoidable. Nurses' note 6/21/21 documents the sighting of a left skin tear on left buttocks and the left heel	S9999		

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S9999	Continued From page 4 noted with dark discoloration. R18 was given heel protectors, skin tear treated, and an MRI scheduled to determine why R18 has the inability to walk and is weak. Review of R18's 6/22/21 pressure wound documentation Wound Assessment Details Report documents the left heel with a pressure ulcer which was acquired within the facility. The skin alteration to the left heel is noted with purple ecchymosis tissue and no drainage. Review of wound Treatment Administration Record (TAR) documents the heel is cleansed with normal saline, patted dry, apply betadine and cover with dry dressing from 6/22/21 to 8/2/21. There was a change in treatment on 8/3/21 to cleanse heel, pat dry, apply thera-honey and cover with dry dressing. This treatment continued to 8/9/21 even though R18 was discharged on 8/5/21 to the hospital. Review of R18's Wound Assessment Details Report dated 6/22/21 documents stage 3 pressure sore on the inner left buttock. It is facility acquired and is 1 centimeter (cm) X 1 cm X0.10 cm (L x W x D) with no undermining. The area was noted to be bright red tissue and some drainage. Review of the TAR documents an order to cleanse left inner buttocks with normal saline, pat dry, apply thera-honey and cover with a hydrocolloid dressing one time a day on Mondays, Wednesdays and Fridays. This treatment was continued until the wound healed on 7/14/21. No documentation was provided to explain why these pressure sores were unavoidable.	S9999		

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S9999	Continued From page 5	S9999		

2. R13's record documented a 56-year-old admitted to facility on 1/12/2021. Minimum Data Set (MDS) for R13 upon admission noted he had no skin breakdown. R13 was non-ambulatory and required assistance of staff for all ADLs. R13's mental status was impaired with a BIMS (Brief Interview for Mental Status) score of 7. R13 was frequently incontinent of bowel and bladder and required total assistance from staff for incontinence care.

BRADEN scale for skin breakdown for R13 was 14 on 6/2/2021, which is high risk for skin breakdown.

Nurses' notes for 8/3/2021 at 10:57AM documented open area on peri area noting that resident was incontinent of bowel and bladder and dependent on staff for care and repositioning. The note documented, "Upon observation site noted with small open area. Resident is incontinent of bowel and bladder. Dependent on staff for care." The wound was staged as Stage 3 on the wound report for R13 on 8/3/2021.

On 8/11/2021 at 12:35PM, V15 (Wound Coordinator) said the open area on R13's coccyx area was because he was incontinent of bowel and bladder.

Care plan for R13's wound care documented two specific intervention for R13, and they were to offload his heels and reposition as needed. On 8/10, 8/11, 8/12 and 8/13 while on unit, there was no offloading of his heels and R13 was always on his left side.

3. R10 was 74 years old and on hospice care. R10 was readmitted to facility on 5/21/2021. R10 depended on staff for all his ADL needs. R10 had

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S9999	Continued From page 6 several wounds about his body, some of which were present upon admission. Treatment to sacral wound which measured 8.5x 9.5x x0.10cm was to be done Mondays, Wednesdays and Fridays. On Wednesday 8/11/2021 at 1:15PM, R10 laid in bed on his left side. When he was repositioned, there was a pungent odor. The right hip wound had an old dressing on it with no date. The under pad had old drainage from the wound. The wound on R10"s sacrum was observed without any dressing. On 8/11/2021 V10 (Certified Nursing Assistant/CNA) did not answer when asked about the last time she changed R10. Facility's Pressure Ulcer policy dated 12/2019 documented, "Avoid prolonged periods of moisture." Also, "Residents will be repositioned according to the individual's level of activity." (B) (Violation 2 of 7) 300.1210b) 300.1210c) 300.1210d)3) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care	S9999		

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S9999	Continued From page 7 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 requirements were not met as evidenced by: Based on interview and record review, the facility failed to safely transfer a cognitively impaired resident (R5). This failure resulted in R5 obtaining an open lower leg fracture that required surgical	S9999		

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S9999	Continued From page 8 intervention. This failure affects one of three residents reviewed for accidents and incidents in a total sample of 19. Findings include: R5 is a 99 year old female. R5's diagnoses include but not limited to: fracture of both lower leg bones, reduced mobility, dementia, osteoporosis, and difficulty walking. Review of R5's Brief Interview for Mental Status (BIMS), dated 11/2019, notes that R5 is not cognitively aware. R5 requires total dependence from staff and requires two people when she is transferred by staff. Fall investigation report dated 1/29/2020, notes V6 (Former Nurse) stated, "I was called to R5's room by V7 (Certified Nursing Assistant/CNA). R5 had left lower leg deformity and bleeding. R5 was crying with her legs dangling to the floor." Initial report dated 1/29/2020, notes R5 who is not alert or oriented, was noted with her leg caught under the bed causing bleeding and deformity to left lower leg after transfer from the wheelchair to the bed by the aide. R5 was assessed by the nurse. Orders were received to send the resident out to a local hospital. R5 was admitted for left leg fracture. On 08/10/2021, at 12:10PM, R5 was in bed. R5 was unable to answer any questions pertaining to the incident of 01/29/2020. On 08/10/2021, at 2:42PM, V7 stated, "I was transferring her by myself. I did not know how many people needed to transfer her. She had a very low bed. She stated that she did not want to	S9999		

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S9999	Continued From page 9 be transferred. I was using a gait belt. I was transferring her from the chair to the bed. Her leg was caught under the bed when I was lowering her. That is when is I heard her scream. I lifted her up again. When I assessed her for injuries, I saw that her leg was broken, and some blood was on the floor. I ran to the nurse. The nurse came back with me. She went to make some calls. She called the ambulance, and they took her to a local hospital. She was given an x-ray. I am always transferring by myself. We are always short of staff." On 08/11/2021, at 1:30PM, V2 (Director of Nursing) stated, "If the resident is a two person assist, I expect that resident to be transferred with two people." On 0812/2021, at 2:32PM, V31 (Physician) stated, "R5's bones are brittle. She does have a diagnosis of osteoporosis. There should be attention to her transfers due to her multiple history of fractures." R5's care plan notes that she requires 24 hour supervision, needs assistance from staff, displays memory impairments, has impaired cognitive function with dementia, and has impaired mobility. X-ray dated 1/30/2020, notes R5 had an open lower leg fracture. (A) (Violation 3 of 7)	S9999		

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S9999	Continued From page 10 300.1210b)2) 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: 2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide documentation on the progress or lack of progress in restorative services for three (R18, R10, R14) of 4 residents reviewed for restorative services in the sample of 19 residents and one resident (R32) outside the sample. This failure resulted in R18 deteriorating in his ranges and ability.	S9999		

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S9999	Continued From page 11 Findings include: 1. On 8/11/21 at 11:29 AM, V41 (R18's daughter) stated that R18 was calling her complaining about much he was declining, and no one is helping with exercises or getting up and out of bed. V41 called the facility on 8/8/21 and instructed the staff to send R18 to the hospital. On 8/12/21 at 10:48 AM, V34 (Physical Therapist) stated R18 was evaluated for skilled therapy on 4/24/21. V34 stated that R18 was assessed for the need of maximum assistance for bed mobility/rolling over in bed, and all other Activities of Daily Living (ADLs) required total assistance. V34 stated R18 was non-ambulatory and struggled to sit up at the bedside of the bed due to restriction in his hip range. V34 stated R18 was discharged from skilled therapy on 6/24/21 and at that time, R18 was moderate assist for transfers, contact guard for bed mobility and able to walk 10 feet on parallel bars with minimum assist. V34 stated R18 was then referred to restorative services. V34 stated that R18 returned to skilled therapy on 7/26/21 due to nurses' referral of significant decline in his ranges and ability. V34 stated when R18 returned to skilled therapy, R18 was maximum assist with bed mobility, total assist with ADLs, non-ambulatory and unable to sit at the bedside. V34 stated that R18 was able to return to sitting at bedside after a few sessions but not able to transfer self on a stand and pivot with assist. V34 stated that R18 was able to regain the ability to stand on feet with parallel bars with limited contact guard before discharge to hospital on 8/8/21. On 8/12/21 at 11:55 AM, V17 (Restorative Licensed Practical Nurse/LPN) stated she will	S9999		

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S9999	Continued From page 12 need to check the dates for restorative services for R18. V17 returned with paperwork documenting R18 was to receive restorative services for active range of motion to upper and lower extremities daily and bed mobility 6 times a week. V17 stated there are no restorative progress notes on R18's participation and progress. V17 stated the restorative notes are just a recap of the information put into the MDS. V17 presented paperwork labeled ADL Significant Change Analysis Report dated 7/8/21 to 7/21/21 that documents R18's decline in walking, locomotion (wheelchair mobility), and toilet use. Another set of the ADL Significant Change Analysis Reports dated 7/23/21 to 8/5/21 document decline in transfer, locomotion, toilet use and bowel continence. V17 stated she is unable to say what caused R18 to decline in these areas. 2. R14 was 65 years old admitted to facility on 5/21/2021. On 8/10/2021 both of R14's hands closed into her palms and her fingernails were long and sunk into the flesh. There was no intervention for her contracted hands. R14's mental status was impaired as she did not answer when spoken to. R14 however shook her head in the affirmative for everything asked. R14 was dependent on staff for all ADLs as noted in the Minimum Data Set (MDS) of 6/15/2021. On 8/12/2021 at 2:10PM, V17 (Restorative Nurse) did not answer when asked about R14's hand. Restorative care plan documented nothing about R14's hands contracture.	S9999		

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S9999	Continued From page 13 3. R10 was 74 years old admitted to facility on 5/2/2019 with diagnoses to include fracture of right femur (hx) and right hip prosthesis. R10 was on hospice care. On 8/10/2021 through 8/13/2021 inclusive R10 was on his left side and his mental status was severely impaired. R10's Brief Interview for Mental Status (BIMS) dated 5/21/2021 scored 11. R10 did not answer any questions asked and surveyor was told by V10 (Certified Nursing Assistant/CNA) that R10 did not speak. R10's right knee was at an angle of about 20 degrees. On 5/15/2019 R10 was ambulatory with supervision for all ADLs as documented. When asked about R10, V17 (Restorative Nurse) said R10 was on hospice care. 4. R32 was 67 years old readmitted to facility on 5/7/2021. R32's mental status was severely impaired with a BIMS of 1 dated 6/28/2021. On 8/10/2021 at 10:20AM, R32 laid in bed. Both of her legs were contracted. Her left knee was about at a 20 degree angle. R32's left wrist was also contracted. Care plan for R32 did not document any intervention for her legs. However, there was documentation for left wrist splint to be on at 8AM and be off at 12PM. From 8/10/2021 thru 8/13/2021 inclusive, there was no implementation of the splint. On 8/12/2021 at 2:10PM, V17 (Restorative Nurse) stated there was no restorative activity staff in the facility. V17 said the facility used the restorative staff to provide direct care to residents when there was a shortage of CNAs. She said	S9999		

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S9999	Continued From page 14 there was a shortage of CNAs more often than not. Facility's policy on Restorative Therapy dated 5/2020 documented, "A resident may be started on a restorative nursing program when he or she is admitted to the facility with functional restorative needs." (B) (Violation 4 of 7) 300.1230e) 300.1230f) Section 300.1230 Direct Care Staffing e) The facility shall schedule nursing personnel so that the nursing needs of all residents are met. f) The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents and shall be determined by figuring the number of hours of direct care each resident needs per day. This requirement was not met as evidence by: Based on observation, interview and record review, the facility failed to meet the minimum staffing requirements which resulted in failure to provide care to the residents. This failure affects all 193 residents in the facility. Findings include:	S9999		

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S9999	Continued From page 15 On 8/10/2021 at 9:45am V2 (Director of Nursing/DON) stated the census at the facility was 193. There were 12 Certified Nursing Assistants (CNAs) and 8 Nurses to care for them for the morning shift. On the second floor, there were three CNAs and two nurses to care for 62 residents. Per observation on 8/10/2021 at 11:00AM, R10, R14, R15 and R16 were in bed and not received cares according to V10 (CNA). Facility's worked schedule indicated that the second floor was consistently staffed with 2-3 CNAs for the first shift. On 8/10/2021, there was only one CNA (V37), who passed the trays on one end of the unit on the second floor. V37 stated, "I have to do everything, and it is rough." On 8/10/2021 at 12:40PM, V30 (CNA) worked on another unit on the second floor and said she was exhausted. She said it is very rough with the number of CNAs on the unit. She said the facility was constantly working short staffed. V30 said she worked on the entire unit by herself several days and the last time was "sometime last week." On another unit another team member had the following observations regarding staffing: On 8/10/2021 at 1:02pm, R11 stated, "I have been asking for a towel since 7am this morning and I still don't have a towel. Whenever I need assistance, there is never anyone here to help me. I have to try the best I can to do things on my own. "	S9999		

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S9999	Continued From page 16 Record review indicates that R11 had frequent incontinence of bowels, R11 is one-person physical assist with ADL (Activities of Daily Living) care, and was ambulatory via wheelchair. On 8/10/2021 at 12:40pm, V16 (Licensed Practical Nurse/LPN) stated, "There are 2 CNAs assigned to the 1st floor with 28 residents, and they have to split the workload on the floor." On 8/26/2021 at 11:26AM, random alert residents including R21 stated, "They never change me on time. They leave me in here sitting in my own urine and there is usually only one CNA working on this floor and she doesn't have time to do everything by herself. " On 8/10/2021 at 11:15am, V24 (LPN) stated, "There are 2 CNAs currently assigned to the 4th floor with a total of 42 residents and the 2 CNAs are required to split the resident workload and care for 21 residents each. On 8/10/2021 at 11:17am V35 (CNA) confirmed that she had 21 residents to care for and stated, "There's supposed to be 3 CNAs on this floor and we're not supposed to have more than 13 patients to care for according to our union contract." On 08/10/2021, at 11:40am, V5 (CNA) stated, "Every day we work short." On 8/12/2021 at 2:10pm, V28 (Staffing Scheduler) said she liked to keep 4-5 Certified Nursing Assistants on the second floor, 4 on the third floor currently with the census. She said any numbers less than those numbers can be considered short staffed.	S9999		

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S9999	Continued From page 17 Facility's policy on staffing (dated 07/14) noted, "Staffing is then increased based on the needs of the resident population." (B) (Violation 5 of 7) 300.690a) 300.690c) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that 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 notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident	S9999		

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S9999	Continued From page 18 to the Department within seven days after the occurrence. This requirement was not met as evidenced by: Based on interview and record review, the facility failed to follow its Abuse Policy, failed to do a thorough investigation, and failed to determine the root cause of the fractures for cognitively impaired, non-ambulatory residents who requires total care for Activities of Daily Living for 2 (R19, R5) of 3 residents reviewed for accident hazards in the sample of 19 residents. Findings include: 1. R19 is an 84 year old, non-ambulatory female who was admitted to the facility on 1/29/20 with diagnoses that include dementia, dysphagia, cerebral vascular accident, thyroid disorder, arthritis per the significant change Minimum Data Set (MDS) 6/25/21. R19 requires extensive assistance with her Activities of Daily Living (ADL) and has a Brief Interview Mental Score (BIMS) of "00" meaning she is severely impaired with cognition. Review of the facility's Abuse Investigation dated 7/30/21 documents that V21 (assigned Certified Nurse Aide/CNA) notified V22 (Registered Nurse/RN) that there was something wrong with R19's thigh area. V22 assessed R19 and ordered an x-ray for R19's left hip and pelvis. The x-ray results showed an "oblique fracture involving the proximal left femoral shaft, suspected to be acute." R19 had no evidence of a fall or injury, so the fracture was classified as an injury of unknown origin. R19 was sent to hospital for evaluation and treatment. Review of staff interview sheets were incomplete and lacking	S9999		

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correct dates of the incident which were changed in the presence of surveyor by V28 (Quality Assurance Licensed Practical Nurse/QALPN). There was no interview from V21 about what she saw before reporting the issue to V22. There was nothing documented in the R19's clinical record of this fracture.

Attempts to interview V21 were unsuccessful.

On 8/11/21 at 12:49 PM, V28 stated she, V32 (previous administrator) and V14 (previous Director of Nursing/DON) did the interviews over the phone with staff. V28 was asked about the discrepancies in the dates for the incident of 7/30/21 and the lack of documentation on days/shifts worked or titles of staff interviewed. V28 stated it was an error in oversight and changed the dates in presence of surveyor and added titles for staff.

On 8/11/21 at 1:07 PM, V14 (Acting Assistant Director of Nursing/ADON) stated R19 had no falls or trauma that was reported. V14 stated the staff interview sheets are supplied by corporation and acknowledged the forms are a checklist and not a true staff statement. V14 stated R19 is in the hospital waiting to be sent to another hospital that has an orthopedic surgeon. V14 stated R19 has yet to be evaluated by an orthopedic surgeon.

On 8/12/21 at 12 Noon, V20 (CNA) stated she was assigned to R19 on 7/29/21 and 7/30/21 during the day shift (6 AM to 2 PM). V20 stated on Thursday, 7/29/21, when she was rendering care to R19 she noticed R19 had a skin tear on her right hip, so she reported it to the charge nurse. V20 stated the charge nurse is new and V20 does not know her name. V20 stated the

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S9999	Continued From page 20 charge nurse asked V20 to assist her with standing R19 up so the charge nurse could view the skin tear better. V20 stated that R19 was on her tippy toes with a little weight bearing due to each on each side holding her up. V20 stated that R19 did not grimace or indicate any pain. V20 stated R19 ate her meals that day without incident and ate well. On 8/12/21 at 12:22 PM, V14 (ADON) stated that R19 was seen by a telehealth physician service and received order to send R19 out to hospital. Surveyor informed V14 that there is no documentation to support the telehealth physician services were ever contacted. On 8/12/21 at 1:16 PM, V19 (CNA) was assigned to R19 on 7/29/21 2pm to 10 pm shift. V19 stated she first saw R19 sitting in her wheelchair. V19 stated at 4 pm she rendered incontinence care to R19 by using the sit to stand machine. V19 stated that R19 is able to place feet on foot platform and hold on to the bars of the sit to stand machine. V19 stated she placed R19 back in wheelchair. V19 stated that R19 did eat her dinner. V19 stated she put R19 to bed at 8:30 PM by picking her up like a baby cradle and placing her into the bed. R19 weighs 85 pounds and 64 inches tall per the weight/height data and 6/25/21 MDS. V19 stated that R19 would usually lay on her left side slightly curled up on a regular mattress. V19 states R19 needs help with bed mobility, speaks gibberish and very low volume. V19 stated that R19's roommate is severely impaired with cognition as well. Both are housed on the dementia floor. V19 stated that R19 was in a low bed, a few inches off the floor along with floor mats. V19 stated she left work at 10:20 PM that night.	S9999		

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S9999	Continued From page 21 There is no documentation to support that R19 was assessed for a sit to stand machine. R19 is non-ambulatory and total care. On 8/12/21 at 4 PM, V22 (RN) stated R19 is a small female who would lay in bed with her knees up to her chest in a curled position and her knees are contracted. V22 stated that he was called to the floor around 10 PM by V21 (CNA) who was assigned to R19. V22 stated that R19, who is normally contracted, was found to have a loose, wobbly thigh that was different than R19's normal. V22 stated the thigh was moving freely which was not normal. V22 stated he tried to get a hold of a physician at the telehealth physician service but was unsuccessful, so he ordered the x-ray himself around 10:30 PM. V22 did not hear about the X-ray results prior to leaving the facility at 7 AM. V22 stated that he was told to write a statement up 2 days ago and stated he wrote the wrong date on written statement by mistake. On 8/13/21 at 9:33 AM, V14 (ADON) stated that staff statements were collected the day of the incident, but they were misplaced and not found so interviews were done again over the phone the last couple of days. The facility's policy Abuse Prevention Program documents all incidents will be documented and any incident resulting in abuse will be investigated. An injury of unknown origin will be documented as to the time it was observed, any treatment given and notification of physician. Attempt to interview the person reporting the incident and any others with direct knowledge of the incident and resident. An investigation that concluded abuse shall be reviewed by Quality Management Committee for possible changes in facility practices to ensure that similar events do	S9999		

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S9999	Continued From page 22 not occur again. Informing local law enforcement immediately when there is a reasonable suspicion of a crime that resulted in serious bodily harm in the facility and a conclusion of the investigation. This policy was not followed by the facility. 2. R5 is a 99 year old female. R5's diagnoses include but not limited to: fracture of both lower leg bones, reduced mobility, dementia, osteoporosis, and difficulty walking. Review of R5's Brief Interview for Mental Status (BIMS), dated 05/17/2021, notes that R5 is not cognitively aware. R5 requires total dependence from staff and requires two people when she is transferred by staff. Facility report dated 07/25/2021, documents R5 was observed with swelling and pain to her right elbow. X-ray ordered to her right arm. X-ray results noted fracture of her elbow. R5 was sent to a local hospital. R5 has a history of previous fractures from home from an elder abuse case. Per admission hospital records, R5 has history of deformity due to weakened bones, osteoporosis, and being prone to fractures. This report was filed to IDPH (Illinois Department of Public Health) as an injury of unknown origin. On 08/10/2021, at 12:10PM, R5 was in bed. R5 was unable to answer any questions pertaining to the incident of 07/25/2021. On 08/12/2021, at 4:07PM, V22 (Nurse) stated, "I cannot remember the male aide's name that was taking care of her. He could not turn her. We pulled her up in bed. R5 guarded her elbow. She would not let anyone touch it. She was a bit confused. She did not say anything, but she	S9999		

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S9999	Continued From page 23 screamed. I filled out the form and called x-ray and left a note for the day shift to follow up on." On 08/12/2021, at 2:06PM, V14 (ADON) stated, "R5 was complaining of pain. R5 got an x-ray. The former Director of Nursing and Assistant Director of Nursing took over for the fractures. It was not a throughout investigation. I cannot find the documentation pertaining to the investigation." On 08/12/2021, at 2:32PM, V31 (Physician) stated, "I was not informed of (R5's) elbow. I am not sure how staff got the x-ray. R5's bones are brittle. She does have a diagnosis of osteoporosis. There should be attention to her transfers due to her multiple history of fractures." (B) (Violation 6 of 7) 300.3260a) 300.3260c) 300.3260g) 300.3260k) 300.3260o) Section 300.3260 Resident's Funds a) A resident shall be permitted to manage his own financial affairs unless he or his guardian or if the resident is a minor, his parent, authorizes the administrator of the facility in writing to manage such resident's financial affairs under subsections (b) through (o) of this Section. (Section 2-102 of the Act)	S9999		

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S9999	Continued From page 24 c) The facility may accept funds from a resident for safekeeping and managing, if it receives written authorization from, in order of priority, the resident or the resident's guardian, if any, or the resident's representative, if any, or the resident's immediate family member, if any; such authorization shall be attested to by a witness who has no pecuniary interest in the facility or its operations, and who is not connected in any way to facility personnel or the administrator in any manner whatsoever. (Section 2-101(2) of the Act) g) The facility shall keep any funds received from a resident for safekeeping in an account separate from the facility's funds, and shall at no time withdraw any part or all of such funds for any purpose other than to return the funds to the resident upon the request of the resident or any other person entitled to make such request, to pay the resident his allowance, or to make any other payment authorized by the resident or any other person entitled to make such authorization. (Section 2-201(6) of the Act) k) The facility shall place any monthly allowance to which a resident is entitled in that resident's personal account, or give it to the resident, unless the facility has written authorization from the resident or the resident's guardian, or if the resident is a minor, his parent, to handle it differently. (Section 2-2-1(9) of the Act) o) The facility shall take all steps necessary to ensure that a personal needs allowance that is placed in a resident's personal account is used exclusively by the resident or for the benefit of the resident. Where such funds are withdrawn from the resident's personal account by any person	S9999		

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S9999	Continued From page 25 other than the resident, the facility shall require such person to whom funds constituting any part of a resident's personal needs allowance are released to execute an affidavit that such funds shall be used exclusively for the benefit of the resident. (Section 2-201(9)(b) of the Act) "Personal needs allowance," for the purposes of this subsection, refers to the monthly allowance allotted by the Illinois Department of Public Aid to public aid recipients. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure an affidavit was executed whenever money was taken from a resident's account, failed to have receipts for the money taken from resident's account to show monies were used for resident, failed to have a written authorization with one witness of no pecuniary interest in the facility or its operations for one (R22) of one reviewed for trust fund monies in the sample of 19 residents. Findings include: Review of the facility's grievances showed a complaint dated 7/6/21 from V42 (R22's nephew) voicing concerns with accessing R22's income. V42 was reimbursed a total of $150. On 8/12/21 at 3:16 PM, V40 (Business Office Manager/BOM) stated that she has been working here since March 2021. V40 stated the first time she met V42 was in June 2021. V40 stated V42 came in this past Monday, 8/9/21 to drop off Power of Attorney papers for finance dated 7/28/21. V40 stated while V42 was in the facility, he was demanding money from R22's trust fund.	S9999		

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S9999	Continued From page 26 V40 stated she did not want to give him the money but was instructed by V32 (previous administrator) and the corporate office to give V42 the money out of R22's account. V40 stated there are no receipts for the money taken by V42. V40 stated she believes this to be abuse because he is not spending the money on R22 and he just cleaned out her account. At 3:40 PM, V40 stated that withdrawals of $90 were given to V42 on 6/25/21, 7/2/21, 7/23/21. V40 stated that V42 received a payment of $150 on 7/12/21 and on 8/12/21, and V42 cleaned out her account of $1160.26. V40 was asked for an affidavit whenever V42 withdrew money from R22's account. V40 stated there is no affidavit and asked how she would go about getting affidavits. V40 presented an authorization form labeled Resident Fund Management Service (RFMS) that allows a resident to deposit their funds into interest bearing account once the amount reaches over $100. The authorization was signed by V42 on 12/31/19. There is no witness on the form. It only has V42's signature with the wording of "Power of Health." There is no documentation of V42 being Power of Attorney for Healthcare. On 8/13/21 at 9:18 AM, V43 (Assistant Business Office Manager) stated the last entry dated 8/12/21 was a check cut to V42. V43 stated that it will be the corporate office that sends the check to her and then she will forward it onto V42. V43 stated that V42 complained to the corporate office about not having access to R22's trust fund. V43 stated that it was V32 who instructed her to give V42 the money from R22's trust fund. V43 stated that there are no receipts for any of the money taken by V42. V43 stated that V42 was claiming he has bought items, such as clothes, shoes and medications for R22, but the items are now	S9999		

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	IL6014823	A. BUILDING: _____ B. WING _____	08/13/2021

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S9999	Continued From page 27 missing. At 12 PM, V43 stated she was able to find withdrawals from R22's account to V42 dated 7/25/20 for $90. V43 presented the cut check from R22's account made out to V42 for $1160.26 dated 8/12/21. V43 stated that the corporate office has instructed her to send him the check. V43 stated that there is no evidence that R22's money was spent on her. Review of R22's trust fund ledger shows withdrawals for $90 on 9/20/20, 12/1/20, 6/25/21, 7/2/21, 7/23/21 and 2 withdrawals on 7/12/21 for $75. The final withdrawal on 8/12/21 was for the $1160.26. R22 is left with $289.36 in her trust fund. R22 did receive a stimulus check of $1400 on 4/7/21, otherwise her monthly income for trust fund is $30 per month. R22 is a severely demented, non-ambulatory 88 year old female who was admitted to the facility on 7/31/19 with severe cognition loss per the admission Minimum Data Set 8/7/19. Nursing Progress notes dated 7/31/21and 8/10/19 document R22 entering facility for short term for rehabilitation after a stroke. R22 lived with V42 in the community and V42 stated that R22 smoked, drank and slept most of the day. R22 has unclear speech and V42 is referred to as "son" but is the nephew. On 8/13/21 at 11:14 AM, V2 (Director of Nursing) stated that there is no policy for trust funds nor the authorizations for handling resident funds. (C) (Violation 7 of 7)	S9999		

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S9999	Continued From page 28 300.3310a)1) Section 300.3310 Complaint Procedures a) A resident shall be permitted to present grievances on behalf of himself and others to the administrator, the Long-Term Care Facility Advisory Board, the residents' advisory council, State governmental agencies or other persons without threat of discharge or reprisal in any form or manner whatsoever. (Section 2-112 of the Act) l) When the Department finds that a provision of Article II of the Act regarding residents' rights has been violated with regard to a particular resident, the Department shall issue an order requiring the facility to reimburse the resident for injuries incurred, or $100, whichever is greater. This requirement was not met as evidenced by: Based on interview and record review, the facility failed to resolve grievances from the resident council minutes and from the facility's written grievances. This failure has the potential to affect all 193 residents residing in the facility. Findings include: On 8/11/21 at 9:45 AM, V2 (Director of Nursing) stated that there are 193 residents in the facility. On 8/11/21 at 11:29 AM, V41 (R18's daughter) stated that R18 was calling her complaining about his phone charger missing, which has happened multiple times. V41 stated she was told that missing items are an on-going issue. There was no complaint seen filed for R18 about a missing phone charger.	S9999		

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S9999	Continued From page 29 The resident council minutes from December 2020, January 2021 through July 2021 document many complaints that have no resolutions. The complaints vary from short staffing, would like to see administrator more and for her to follow up on concerns, residents saying they need more help than they are receiving, medications are late, need help with discharge planning, missing items in laundry, rooms not thoroughly cleaned, and call light response is slow. Many of these complaints were repetitive from month to month. On 8/12/21 at 11:43 AM, V23 (Activity Director) stated there are no resolutions to the complaints in resident council. Review of the facility's grievances show many of the same concerns from the resident council. Some of the resolutions were reimbursement of money but no documentation the money was given. There were five complaints, one on 7/27/21, two on 7/28/21, and 2 on 8/2/21, none of which had any resolution. The complaints were missing clothes and were from five different individuals (R3, R25, R26, R28 and R29). R30 complained on 6/10/21 of missing clothes and resolution was to give her $85, but no documentation it was given to R29. R31 complained about staff's attitudes on 1/7/21. On 8/12/21 at 2 PM, V1 (Vice President of Operations) stated if there is no proof of money being reimbursed, he knows it was not done. The facility's policy Grievances documents the facility must make prompt efforts to resolve complaints. The complaint will be given to the appropriate department head and the department head is responsible for investigating the	S9999		

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S9999	Continued From page 30 complaint and speaking with resident or family member who made the complaint regarding both the complaint and possible resolution. The department head will complete bottom of the grievance form including any pertinent information including but not limited to a summary of the findings or conclusion and any corrective actions and forward to the Administrator. This policy was not followed. (C)	S9999		