STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015473	A. BUILDING: _____ B. WING _____	C 08/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT QUINCY	1707 NORTH 12TH STREET QUINCY, IL 62301

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S 000	Initial Comments Facility Report Investigation to Incident of 8/09/21 /IL137192 - No findings. Facility Report Investigation to Incident of 8/16/21 IL137197 Illinois Veteran's Home Code Section 340.1505 (g) cited. Original Complaint Investigation 2126068/IL137323 - Illinois Veteran's Home Code Section 340.1560 (a) and 340.1505 (g) cited.	S 000		
S9999	Final Observations Statement of Licensure Violation: 1 of 2 Violations: Section 340.1505 Medical, Nursing and Restorative Services (g) All necessary precautions shall be taken to assure that the resident's 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to adequately supervise a resident with a history of multiple falls, for one of three residents (R2) reviewed for falls in a sample of four. This failure resulted in R2 falling in his room as he attempted to toilet himself, sustaining a Subdural Hematoma and sutures to the forehead.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Findings include: The electronic Medical Record documents R2 was admitted to the facility on 5/17/21 with the diagnosis of Dementia without Behavioral Disturbances. At that time, a Fall Risk Assessment was completed and R2 was determined to be at high risk for falling. A Plan of Care, initiated 5/18/21, identifies R2 as having limited physical mobility related to Confusion, Dementia, Glaucoma, psychotropic medication use (Ativan, Melatonin), impaired short-term and long-term memory problems, poor impulse control, anxiety, and poor trunk control and being at High Risk for Falls related to weakness, altered mobility, history of frequent falls, impaired gait and balance, needing an assistive device for walking and transfers, and forgetting his limitations. A 5/24/21 Minimum Data Set assessment documents R2 has having significant cognitive impairment, needing the extensive assistance of one staff member to transfer and the extensive assistance of two staff to ambulate on the unit. Nursing Notes document R2 experienced staff witnessed falls on the following dates: 5/22/21, 6/26/21, 6/30/21 and 7/19/21. Nursing Notes document R2 experienced unwitnessed falls on the following dates: 5/30/21, 6/14/21, 6/15/21, 6/22/21, 6/23/21, 7/10/21 and 8/14/21. R2's Plan of Care documents nursing staff implemented ongoing visualization/observation of R2 every 15 minutes after the first unwitnessed fall, on 5/30/21. Fall investigations document that R2 was placed on a toileting schedule after the 6/23/21 fall and R2's room was moved closer to the nurses station after the 6/30/21 fall. All the other fall investigations instructed staff to continue monitoring R2 on a every 15 minute basis as a fall prevention intervention.	S9999		

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S9999	Continued From page 2 On 8/16/21 at 6:20 pm, Nursing Notes document, "staff in the hall had heard the bed alarm from (R2's) bed, on getting to the room, (R2) found on the floor in between the room door and the bathroom door. When this nurse got to the room, (R2) was lying face up and was bleeding from the top part of his forehead. (R2) had told (Certified Nursing Assistant) that he was going to use the bathroom when he fell. 911 was immediately called." An Initial Fall Investigation, dated 8/16/21, documents R2 was admitted to the local hospital due to a CT scan of the brain showing R2 developed an acute subdural hematoma in the right frontal/parietal convexity of the brain and a scalp laceration. On 8/19/21 at 1:51 pm, R2 was lying in bed asleep. R2 had a golf ball size hematoma, which contained multiple sutures, in the middle of his forehead, along with bruising under both eyes. On 8/22/21 at 2:23 pm, V5 (Certified Nursing Assistant) stated the evening of 8/16/21, they had only two CNAs (Certified Nursing Assistants) and they normally have three. V5 stated she and she and V4 (Certified Nursing Assistant) had been busy giving other residents incontinence care and getting residents up for dinner. V5 stated the last she observed R2, he was in his room, asleep, with the door open, which is across from the nurses station. V5 stated there was no staff at the nurses station at that time. V5 stated they heard R2's bed alarm sound when they were at the other end of the hall. According to V5, when they got to R2's room the door was closed. V5 believes another resident heard the alarm and closed the door on R2. Upon opening the door, R2 was found lying on the ground, near the bathroom door. R2 told V5 he was trying to go to	S9999		

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the bathroom. V5 stated, "with only two CNAs on the unit, it's hard to keep watch of (R2)." V5 explained that they keep R2's walker next to the bed, because he's so unpredictable and quick. V5 stated, R2 will get out of bed on his own and doesn't understand that he can't walk long distances. V5 stated that unit has been short staffed for several weeks now and R2 really needs 1:1 supervision most of the time, which can't be provided.

On 8/18/21 at 2:55 pm, V4 (Certified Nursing Assistant) stated the evening of 8/16/21, the Unit was short staffed, with one licensed nurse and two CNAs. V4 stated she and V5 heard R2's bed alarm as they ambulated another resident down the hall. V4 stated they found R2 face down on the floor, with an obvious injury to his head. V4 stated R2 can get out of bed and ambulate a short distance independently, but needs a wheeled walker or a railing to do so safely. V4 stated R2 is too confused to realize he can't ambulate on his own and will frequently think he's able to "just go." V4 stated that's why he has had so many falls and he is on every 15 minute visual checks, but R2 really needs watched closer than that.

On 8/18/21 at 1:10 pm, V3 (Nursing Supervisor) stated that the minimum staffing for R2's Unit (B) on second shift would be one licensed staff and 3-4 CNAs. V3 stated R2 is ambulatory with a wheeled walker, but is too demented to remember to take it and R2 can't be educated because of his dementia. V3 concluded, R2 has had multiple falls and they do investigate them, but new interventions to prevent him from falling are difficult to come up with. V3 stated every 15 minute visual checks is the only intervention she can think of at this point due to the number of

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S9999	Continued From page 4 men on that unit that are fall risks. V3 stated the only other option to prevent R2 from falling is 1:1 supervision and "we don't have the staff to provide that." (B) 2 of 2 Violations: Section 340.1560 Nursing Personnel (a) There shall be sufficient number of nursing and auxiliary personnel on duty each day to provide adequate and properly supervised nursing services to meet the nursing needs of the residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to meet staffing requirements on the Dementia Unit (B), resulting in lack of resident supervision. This failure has the potential to affect all 23 residents that currently reside on that unit. Findings include: A Facility Staffing Sheet, no date, outlines the total number of staff required to provide resident care on each specific unit throughout the campus the facility is located on. This Facility Staffing Sheet documents, for a census of 23, the Dementia Unit (B) is to have one licensed nurse present for 1st, 2nd and 3rd shift. It also documents they are to have a minimum of 4 CNAs on 1st shift and a minimum of 3 CNAs on 2nd and 3rd shift.	S9999		

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S9999	Continued From page 5 Daily Staffing Sheets for 8/20/21 (Dementia Unit B) document 1st shift had three CNAs and 3rd shift had two CNAs, leaving each of the shifts short one CNA. Daily Staffing Sheets for 8/21/21 (Dementia Unit B) document 1st and 2nd shift had two CNAs for the full shift along with an additional CNA that worked half of each of those shifts, and 3rd shift had two CNAs. This would leave the 1st shift short by 1.5 CNAs, 2nd shift short one person for 1/2 the shift and 3rd shift short one CNA. Daily Staffing Sheets for 8/22/21 (Dementia Unit B) document 1st shift had three CNAs, 2nd shift had one CNA, and 3rd shift had one Licensed Nurse that was shared with the other Dementia Unit (A) along with two CNAs. This would leave the 1st shift short one CNA, 2nd shift short two CNAs and 3rd shift short Licensed Nursing staff and one CNA. On 8/23/21 at 1:41 pm, V6 (Certified Nursing Assistant) stated staffing on (Dementia Unit B) has been poor and there are not enough staff to effectively monitor the residents with Dementia, many of which are independently ambulatory. V6 stated she recently worked the 3rd shift of 8/21/21 and they were short one CNA. V6 stated she noted R3 walking in the halls, naked with feces on him. V6 and the only other CNA (V7) on that unit, directed R3 to the shower room. V6 stated R3 became physically agitated towards both of them, yelling, and backing both of them into the corner of the shower room. V6 stated they yelled for help from the Registered Nurse (V8), who came and redirected R3 away from them. V6 stated, while all of this was going on, there was no one to supervise other residents. V6 stated that unit currently has eight residents	S9999		

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that they have to do every 15 minute checks on (due to aggressive behaviors or being a fall risk). V6 explained, with only two CNAs, that is extremely difficult to do. V6 stated staff are leaving because they are tired of working so short staffed and trying to safely handle resident behaviors. V6 stated that they currently don't have the staff to protect other residents from R3, because he has to be watched constantly and needs 1:1. V6 explained that R3 is very demented and has Post Traumatic Stress Disorder, which has left him very unpredictable in his behaviors, which include violent outburst towards staff and residents.

On 8/23/21 at 1:55 pm, V7 (Certified Nursing Assistant) stated she worked on the third shift of 8/21/21, and they were short staffed with only one RN and two CNAs. During that shift, V7 stated R3 was walking naked and soiled with feces, so she and V6 directed him to the shower room. According to V7, R3 became physically and verbally aggressive, cornering them in the bathroom and they had to yell for help. V7 stated R3 was swinging his fists at both of them. V7 stated they screamed for help from V8, who did come and deescalate R3's behavior. V7 stated that there are usually 3 CNAs, sometimes 4, and a nurse, on third shift. V7 explained that the unit needs at least three CNAs because of the 8 residents that are on every 15 min checks for behaviors or falling. V7 stated if R3 gets "mad at another resident, he will attack", which is why he needs 1:1 supervision, and they do not have the ability to do that if they are short staffed.

On 8/24/21 at 8:49 am, V8 (Registered Nurse) stated, in the early morning of third shift on 8/21/21, he observed R3 naked in the hall with feces all over him, so he directed V6 and V7 to

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take him to the shower and attempt to clean him up. V8 stated two staff have to provide direct care to R3, due to his aggressive behaviors. V8 explained R3 has been physically aggressive towards staff on numerous occasions, such as punching in the face and head, putting his hands around throats and throwing objects, so they try to care for him with two staff. According to V8, as R3 was being directed into the bathroom, he heard R2's bed alarm sound down the hallway. V8 was concerned, because R2 had recently fallen (on 8/16/21) and sustained a Subdural Hematoma with sutures. V8 found R3 attempting to ambulate independently in his room and was trying to redirect him to his bed, when he heard screams for help from V6 and V7. V8 hurriedly returned R2 to his bed, but had to leave him unsupervised because the unit had no other staff. V8 found V6 and V7 cornered by R3, who was attempting physical aggression towards them and swinging his fists. V8 stated he was able to calm R3 and R2 did "luckily" remain in his bed. V8 stated R3 can be like a "light switch" and go from pleasant to scaring staff and residents, and R3 really needs 1:1 or a modified 1:1, but they just don't have the staff to do it right now. V8 stated he has concerns for R2's safety, as he is "very active" and can go from "sitting, to standing, to almost falling within seconds, and really needs to be 1:1 at times." V8 stated there are some 3rd shifts where it is only one licensed staff and one CNA, which is unsafe for residents and staff. V8 explained, with the staffing numbers they had 8/20/21 - 8/22/21, "you can't effectively monitor these men" or "properly do every 15 minute checks on eight residents." V8 stated adequate supervision of these Demented residents is impossible when they are understaffed.

On 8/24/21 at 11:42 am, V9 (Registered Nurse)

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S9999	Continued From page 8 stated V9 stated she worked this past weekend on the second shift with just her and one CNA, which is "not enough to supervise the residents at the level they need." V9 explained that a few residents have significant behaviors, specifically R3. V9 stated R3 "can go from playful to angry in seconds and little things will set him off, such as another resident coughing during an activity." V9 explained R3 is on every 15 minute visual checks and activities/staff will do a modified 1:1 with R3 at times, but "we need the staff to do that and we currently don't have that, especially on 3-11 shift." V9 stated, to effectively monitor all resident behavior on (Dementia Unit B), she needs four CNA's and herself on 1st shift, V9 explained those numbers "change drastically at 3:00 pm when 2nd shift arrives and they often decrease to 3-2 CNAs." V9 expressed that R3's and other residents' behaviors can be managed, if they have the appropriate number of staff, but they currently don't. On 8/23/21 at 11:32 am, V2 (Director of Nursing) stated the facility is currently short of staff and confirmed that the Dementia Unit (B) was short of staff this last weekend. V2 concluded that the facility has many open positions that they are actively trying to fill, but many applicants grades for the posted positions are awaiting approval/grading by the State Agency that completes that process. A Daily Census Detail for Dementia Unit (B), dated 8/19/21, document 23 residents currently reside there. (B) .	S9999		