STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008130	A. BUILDING: _____ B. WING _____	C 09/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS AT ROCK ISLAND	2545 24TH STREET ROCK ISLAND, IL 61201

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S 000	Initial Comments Facility Reported Incident (FRI) Investigation to Incident of 9-5-21/IL 137866	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210a)b) 300.1210d)6) 300.1220b)2) Section 300.1210 General Requirements for Nursing and Personal Care a)Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. These Requirements were not met evidencded by: Based on interview, and record review, the facility failed to provide a resident with safety interventions and provide adequate supervision to ensure R1, a newly admitted resident with a recent history of a suicide attempt, did not	S9999		

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S9999	Continued From page 2	S9999		

engage in behavior of self-harm and maintained a safe environment free of hazards for one of three residents R1 reviewed for supervision, in a total sample of three.

Findings include:

R1's Pre-admission documentation, titled "History & Physical Note", printed on 9/1/21, documents, "Patient R1was recently admitted on 8/23/21 to local hospital and was discharged on 8/28/21 for intentional ingestion of batteries"; "Consultation Note" under "Assessment/Plan"-"Intentional ingestion of batteries of two batteries. Bipolar and Schizoaffective disorder. Auditory hallucination and suicidal attempt."

On 9/9/21, at 9:30 AM, V5/Marketing-Hospital Liaison confirmed during the screening process that R1 was determined to be "in the yellow" meaning "take a second look at R1 prior to admission"; V5 stated, "R1 was in the yellow "because she was COVID-19 positive, depression, psychiatric issues, and swallowing batteries which was shared to the facility in my email." V5 stated "would definitely not give R1 batteries knowing R1 had a recent history of swallowing batteries".

V5's electronic mail correspondence, dated 9/1/21, documents the recipients included: V1/Administrator, V2/Director of Nursing, V3/Assistant Director of Nursing, V6/Senior Vice President, and V7/Regional Director. V5's electronic mail documents, "Good Evening team, new referral, patient R1 is COVID-19 positive, Bipolar disorder, and she also swallowed batteries a week ago, she is also on 4L (liters) of O2 [oxygen] she is 403 pounds, her stay will be

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S9999	Continued From page 3 (rehabilitation) only, and will return to [another assisted living facility] after her discharge. Fasttrack is attached please advise thank you." R1's Electronic Medical Record (EMR) documents R1 was admitted to the facility on 9/4/21 at 7:02 p.m. R1's EMR does not contain a Care Plan/Interim Care Plan, nor suicide risk assessments. R1's EMR, dated 9/5/21 at 10:04 a.m., document, "R1 continuously screaming inappropriate words to RN (Registered Nurse) and CNA (Certified Nursing Assistant) this morning. All medications given; Lidocaine patch placed on Lumbar area with assistance from CNA for placement. At approximately 10:05 a.m., R1 screamed out 'I just ate the batteries, now what do you think of that?' CNA and Nurse went into R1's room and the (television) remote was on the bedside table with the battery cover removed, batteries missing. 911 called and a search for the batteries took place in her room. Batteries were not found. V10/Nurse Practitioner contacted. No (POA) Power of Attorney information provided in paperwork, R1 stated, "she had no one". R1 alert, and stable upon local Fire Department arrival to facility. Assist of two given to place on gurney. Commands followed with instructions to pivot and sit on gurney." R1's Local hospital documentation, dated 9/5/21, document, in part, "D: R1 at local long term care facility brought to the (ED) Emergency Department for depression, (SI) Suicidal Ideation with attempt by ingesting batteries. Per report, R1 said she swallowed one a couple days ago and two more today with intent to kill herself as she doesn't like it at the local long term care facility. R1 tested positive for COVID about five days ago.	S9999		

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At 12:12 PM, Looks to have batteries in stomach and one in small intestine. (GI) Gastro-intestinal paged. 1:00 PM, spoke with (GI) doctor who recommends daily x-rays until batteries passed." At the time of the State Survey, R1 remained hospitalized, and batteries remained inside of R1.

On 9/8/21, at 9:15 AM, V4, Care Plan coordinator confirmed that no Care Plan, nor Interim Care Plan had been done for R1.

On 9/8/21, at 9:25 AM, V1 (Administrator) confirmed knowing R1 had ingested batteries approximately a week prior to R1 being admitted to the nursing facility on 9/4/21. In addition, V1 confirmed R1 had no Care Plan, nor Interim Care Plan addressing R1's specific needs.

On 9/9/21, at 3:50 PM, V1 confirmed the admitting staff should have known about R1's past battery swallowing incident. V1 stated "staff should review the referral packet which contains all information on the incoming resident".

On 9/8/21, at 2:10 PM, V11/Registered Nurse confirmed V11 was the nurse that did R1's admission on 9/4/21. V11 stated "while receiving phone report, from the hospital, V11 was told R1 was on suicide precautions. V11 immediately called V2 (Director of Nursing) who in turn called the hospital to verify". V11 stated "V2 reported back that R1 was not on suicide precautions". V11 confirmed having no idea about R1's previous battery swallowing incident, and R1 was not placed on suicide precautions.

On 9/9/21 8:50 AM, V2 (Director of Nursing) stated "V2 told V11/Registered Nurse who admitted R1 to "be cautious because R1 did have a problem with swallowing batteries." "I did not

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want to be lackadaisical"; and "I didn't come out directly and say don't give anything with batteries". V2 confirmed, based on knowledge of R1's past battery swallowing, that R1 should not have had the remote-control containing batteries.

On 9/9/21, at 4:10 PM, V2 stated, "Nurses are supposed to use an admission check off audit form which some do, and some don't." V2 confirmed V11 did not use the audit form, entitled "24-48hr Admission/Readmission Reconciliation/Audit", updated 5/2021, which documents, in part, under "Checklist", "Admission packet under observation in the EMR" which would directed V11 to review the history of R1, had it been completed, the admitting nurse would have known of R1's previous battery swallowing hospitalization, as reviewing the admission packet is part of the admitting process.

On 9/10/21, at 9:20 AM, V12/Activity Aide stated "V12 knew nothing of R1 and never saw R1, V12 stated since R1 is on a COVID unit, she never entered the unit. V12 would leave coloring books and pencils with nurses".

On 9/10/21, at 10:15 AM, V14/CNA confirmed working with R1 the day R1 was sent out to the hospital on (9/5/21). V14 confirmed R1 was verbally abusive to V14 by making racial slurs, and other name calling. V14 confirmed she was not aware of R1's previous suicide attempt by swallowing batteries. V14 also stated she was "unaware of any suicide precautions for R1".

On 9/10/21, at 10:30 AM, V15/Registered Nurse confirmed: working on the COVID Unit, with R1, the day R1 ingested the batteries (9/5/21); V15 stated she was in the hallway when she heard R1 yell that R1 swallowed batteries; when entering

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S9999	Continued From page 6 R1's room, V15 saw the television remote laying upside down with a battery cover off and the batteries missing; a quick cursory search was done and 911 was notified; V15 stated she "was not aware of R1's previous suicide attempt by swallowing batteries; and no suicide assessments were done during R1's brief stay". On 9/10/21, at 11:15 AM, V16/Maintenance confirmed making sure R1's room was set up with a working television and remote control. V16 confirmed V16 had no knowledge of R1's past battery swallowing incident. V16 confirmed R1 was not on any precautions that would prohibit items containing batteries. " B "	S9999		