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S 000	Initial Comments Annual Health Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.610c)4)A) 300.625k) 300.690a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. c) The written policies shall include, at a minimum the following provisions: 4) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs Section 300.625 Identified Offenders k) The facility shall incorporate the Identified Offender Report and Recommendation into the identified offender's care plan. (Section 2-201.6(f) of the Act) 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. 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	S9999		

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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.

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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These regulations are not met as evidenced by:

Based on interview, record review and

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observation, the facility failed to investigate falls and provide fall interventions and failed to follow recommendations for supervision and safety of other residents for 5 of 8 residents (R24, R26, R56, R57, R69) reviewed for accidents and supervision in the sample of 36. This resulted in R56 sustaining a fall with a head laceration requiring 10 sutures.

Findings include:

1. R56's Electronic Medical Diagnosis Sheet documents, diagnosis of Chronic Respiratory Failure with hypoxia, Persistent Vegetative State and encounter for attention of tracheostomy.

R56's MDS, dated 12/28/20, documents R56 is totally dependent on 2 staff members for bed mobility.

R56's Care Plan documents, "(R56) is at risk for falls r/t DX (diagnoses) Seizure disorder, muscle spasms. 12/11/20 Observed on floor. 1/29/2021 Observed on floor next to bed." Interventions include: Use positioning device to assist with maintaining proper alignment/positioning when in bed due to muscle spasm (Dated 1/29/21). (the other interventions are undated) Bolsters mattress cover for over LAL (Low Air Loss) mattress. Check LAL mattress with all care and rounds to ensure proper inflation. x 2 with bed mobility. Keep bed in lowest position at all times except for when providing care. Mattress on floor along side bed. Do NOT position him close to wall, center him in the bed when positioning. Use positioning device to assist with maintaining proper alignment/positioning when in bed due to muscle spasm. Monitor for s/s (signs and symptoms) of seizure. Notify nurse when symptoms are present. Place resident on his side

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S9999	Continued From page 4 for safety during seizure. R56's Nurse Progress Note, dated 12/11/2020 at 7:07 PM, documents, "Walked pass Pt. (patient) room & found Pt laying on the pad on the floor. Assessment found a 2" (inch) "L" shaped skin tear to (L) [left] eyebrow. Mother was made aware & she wanted Pt. sent to Hospital for an eval. (evaluation) Call placed to hospital Emergency Room & gave report. Call was placed to Ambulance for transfer." R56's Nurse Progress Note, dated 12/12/2020 at 04:34 AM, documents, "Res returned from Hospital at this time Res has 10 sutures to L-shaped wound at left eyebrow line. No active bleeding noted. Sutures to come out in 5 days." The facility was unable to provide an investigation of this fall for review. R56's Nurses Notes, dated 1/29/2021 at 5:11 PM, documents, "The resident was noted on the floor mattress at bedside, the lo-bed was in it's lowest position. Upon physical assessment, no signs of injury noted. The resident's vital signs were assessed and vital signs within the resident's normal limits. The resident was transferred from floor mattress to his bed via 2 assist without difficulty." R56's Fall Investigation, dated 1/29/21, documents, New Interventions: "Mattress overlay bolster mattress over LAL (low air loss). Ensure proper inflation of LAL. Position center of bed. Bed in lowest position. Root cause: Res (resident) occasionally and will cough so hard he will throw self from bed." On 2/9/21 at 11:00 AM, R56 was in a LAL	S9999		

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mattress. No bolster overlay was in place. V5, CNA, placed a small wedge cushion under R56's knees.

On 2/9/21 at 11:00 AM, V5 stated that she was present when R56 was found on the floor and that R56 coughs very hard at times and he can fall out of bed while coughing. V5 further stated that staff use a wedge cushion to keep R56 from being able to fall out of bed.

On 2/10/21 at 3:00 PM, V1 Administrator, stated that he was unable to locate an investigation of R56's fall on 12/11/20. V1 also agrees that R26's fall investigations do not document root cause analyses.

On 2/11/21 at 2:09 PM, V1, Administrator, stated, "The facility does not have a fall policy." V1 further stated, "I would expect staff to do a full investigation of the fall and to determine a root cause analysis of the fall."

2. On 02/02/21 at 12:50 PM, R24 was sitting in his wheelchair in the doorway of his room. R24 propelled his wheelchair in his room. R24's room was located at the very end of the hallway, farthest from the nurses station.

On 02/02/21 at 12:52 PM, V28, Certified Nurses Aide (CNA), stated, "He does not wander into others rooms, but he does go up to the nurses station to make phone calls."

On 2/9/2021 at 12:35 PM, V8, Social Services Director, stated, "I am not sure why (R24) is at the end of the hall. I guess it is because the rooms at the top of the hall are not private rooms or private bathrooms. To my knowledge, he has not went to any other persons room." V8 was

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S9999	Continued From page 6 unable to state how long R24 had been in the very last room on the hall. On 2/9/21 at 1:39 PM, V13 Licensed Practical Nurse (LPN), stated that R24 has no special observations or monitoring. V13 further stated that he will go to the double doors at the top of the hall, but can be redirected. R24's Admission Record, print date of 2/10/21, documents R24 was admitted on 8/8/2019 with diagnoses of history of malignant neoplasm of the brain, Paranoid Schizophrenia, and Dementia with behavioral Disturbances. R24's Illinois Department of Public Health Identified Offenders Program, dated 9/16/2019, documents, "High Risk. The resident requires a single room in close proximity to the nursing station to permit ongoing visual monitoring. The level of observation should be sufficient for early detection of behavior changes. Regular assessment is necessary to determine whether closer monitoring or more frequent individual contact is indicated." R24's Minimum Data Set (MDS), dated 12/16/2021, documents R24 is severely cognitively impaired, requires extensive assist of 1 staff member for transfer and R24 uses a wheelchair for locomotion. This MDS documents locomotion on the unit activity did not happen. R24's undated Care Plan, documents, "(R24) is at risk for sexually inappropriate behavior towards others r/t (related to) Attempted Deviate Sexual Assault. He is a registered sex offender. Additional offenses include Narcotics, Burglary, Unlawful restraint, Murder, Battery. Interventions: Single room. Regular monitoring to determine	S9999		

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whether close monitoring or more frequent individual contact is indicated. 1:1 visits to monitor for changes in behavior and mood as indicated. Private bath. No contact with children. Must stay 500 feet away from schools, daycare. Must notify the police department if he exits facility for any reason. Parole officer to visit as ordered by the judge. Monitor/document/report PRN (as needed) any s/sx (symptoms) of resident posing danger to self and others. He is not to go into other residents rooms, male or female."

The facility Sexual Offender Policy, dated 7/21/2005, documents, "Standard: In order to protect current residents in the facility, all potential admissions will be checked against the Sex Offender Registry and Department of Corrections websites for felony convictions in accordance with State, local and government rules and regulations." It continues, Policy: #6) The facility will follow all policies established by the local law enforcement in regards to registration of sex offenders."

3. R26's Admission Record, print date of 2/10/21, documents R26 was admitted on 8/2/2018 with diagnoses of Aneurysm of Carotid Artery and Dementia.

R26's MDS, dated 1/21/2021, documents R26 is severely cognitively impaired, requires extensive assist of 2 staff members for bed mobility, and is totally dependant on 2 staff members for transfer.

R26's Fall investigation, dated 11/3/2020, documents, "Nursing Description: This nurse was called into residents room by CNA that stated she had sat resident up at her bedside turned and went to the door and heard her fall. Noted

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resident lying on her right side by her bed. Immediate Action Taken: Active and passive range of motion done. Resident was able to move all extremities without assistance with limited motions due to age without indications of having pain. Was able to tolerate Passive range of motion. CNA was informed not to leave any residents that requires assistance with transfers unattended when sitting up at the bedside." New Intervention: "Instruct staff resident not to be left alone sitting on side of bed."

R26's Nurses Notes, dated 12/6/2020 at 11:45 PM, documents, "this pt's c.n.a. called this nurse down to her room, this pt was found laying on the floor next to her bed on her right side, her head was up on her tennis shoes. she was assessed, a mechanical lift pad was placed under her, she was placed back in bed by this nurse and her c.n.a. her range of motion has not changed, she stated she is ok. neuro checks were started at this time."

R26's Fall investigation, dated 12/6/20, documents a New Intervention: "Staff instructed to make sure resident in center of bed when turned."

R26's Fall Investigation, dated 1/31/21 at 12:45 AM, documents, "Nursing Description: Called to room by CNA and noted res (resident) lying on floor next to her bed on her left side of face resting on night stand. Immediate Action taken: assessed for injury, assisted to bed per mechanical lift, ice pack applied to face, positioned on right side facing wall with cushions behind her, kept in bed in lowest position and applied mat on floor next to bed. New Intervention: Bed at lowest position. Positioning away from side of bed during rounds." This fall

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investigation does not document a root cause analysis of the fall.

R26's Fall Investigation, dated 2/2/21 at 10:30 AM, documents, "Nursing Description: This nurse noted resident lying on the floor with her bed covers under her roommate called out for help. New Intervention: Resident rolled from bed. Instructed to use call light for assist. Head of bed lowered after meals. call light within reach." This fall investigation does not document a root cause analysis of the fall which would assist in determining appropriate interventions. R26 has severe cognitive impairment, instructions to use call light would be ineffective for this resident.

4. R69's Care Plan, dated 5/25/2020, documents, "(R69) is at risk for injury, skin breakdown r/t (related to) DX Peristomal leakage at gtube (gastrostomy tube) site, impaired mobility, combativeness, moisture against skin. Intervention: Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Roll up cloth and place between his left arm and body r/t him drawing his left arm into his body. Geri sleeves to RUE (right upper extremity) at all times, remove for shower and skin check then reapply.

R69's Skin/Wound Note, dated 2/8/21 at 3:00 PM, documents "Note Text: Noted skin tear to right hand 1.5 x 1.3 x 0.2 beefy red with moderate serosang drainage. MD (Physician) made aware and new order received to apply TAO (triple antibiotic ointment) and dry dressing daily and prn. Order noted and RP made aware. Dressing applied as orders."

On 2/2/2021 at 9:55 AM, R69 was sitting in his

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reclining wheelchair with a short sleeve shirt on with both arms exposed. R69 had multiple bruising in various stages of healing to both arms and hands. Arm protectors and the rolled up cloth were not in place.

On 2/3/2021 from 11:15 AM to 1:50 PM, based on 30 minute observation intervals, R69 was without arm protectors and rolled up cloth in place.

On 2/4/2021 from 9:30 AM to 12:50 AM, at 30 minutes observation intervals, R69 was without arm protectors and the rolled up cloth were not in place.

On 2/8/2021 at 930 AM, R69 was sitting in his recliner with a large bandage to his left hand.

On/9/2021 at 9:45 AM, V5, CNA, stated, "(R69's) skin is real thin. It's like newspaper. We have to be careful with his hands and arms. They bruise and tear easily. When he first got here, he was wrapped up all the time. You can barely touch him and he would bruise or his skin would tear."

On 2/8/2021 at 1:40 AM, V12, CNA, stated, "Day shift starts at 6:30 AM and ends at 2:30 PM. (R69) is gotten up on midnights and stays up until after lunch. He does not move around in his chair."

On 2/9/2021 at 2:30 PM, V3, LPN, stated R69 bruises easily. "He is supposed to have his arm protectors on. This will help prevent the bruising and skin tears."

R69's Clinical Record does not document bruising to R69's arms and hands.

On 2/9/2021 at 2:28 PM, R69's documentation

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S9999	Continued From page 11 related to bruising and any incidents related to bruising and skin tears requested. On 2/9/2021 at 2:30 PM, V2, Director of Nursing, stated she was not aware of R69's bruising and is not aware of an investigation into the areas. On 2/9/2021, V18, LPN, stated the skin assessments are done on shower days and documented on the shower sheets. CNA supervisor keeps those. 2/9/20 at 3:30 pm V5, CNA, stated the reason she hasn't brought the shower sheets in was because there is no documentation of R69's bruises. R69's Clinical Record had no documentation of his bruising or a root cause analysis to determine appropriate interventions for prevention. 5. R57's Care Plan, dated 2/5/2021, documents (R57) is at risk for falls r/t poor safety awareness, weakness and shuffled/scissor gait. Does not recall that he has limitations due to Alzheimer disease, history of vertigo, and impaired eyesight. 6/15/2020 Observed on floor, 9/1/2020 Observed on floor, 1/14/2021 Observed on floor, 1/20/2021 Observed on floor, 1/26/2021 Observed on floor, 1/28/2021 Observed on floor, 1/31/2021 Observed on floor. Interventions: Staff to assist with transfer to wheelchair or x1 assist with ambulation if noted to being awake and wanting to get out of bed. Ensure that The resident is wearing appropriate footwear when ambulating or mobilizing in w/c. x1 assist with ambulating him on the hall when he is restless or agitated. R57's MDS, dated 12/24/2020, documents R57 is severely cognitively impaired and requires limited	S9999		

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S9999	Continued From page 12 assist of one person for transfers. R57's Morse Fall Scale, dated 12/24/2021, documents high risk for falls. From 1/1/2021 to 2/8/2021, the Incident and Accident Reports (IAR's) documented R57 had 6 falls. On 2/8/2021, R57 was ambulating, with socks on, in his room without assist. R57 was observed tripping over the wheels of his wheelchair. V12 attempted to redirect and grabbed a hold of R57 right arm and encouraged R57 to sit in the wheelchair. R57 fell to floor. V12 and V14 transferred R57 from floor to wheelchair. V12 and V14 lifted R57 placing their arms under R57's armpits and grabbed his pants. V12 and V14 did not use a gait belt with transfer and transferred before R57 was assessed for injury. On 2/8/2021, V12 stated "It's hard because he (R57) doesn't remember things. He used to walk around. He stays in his room. We try to redirect him but it's only a sort time and he is back up." (B)	S9999		