Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| TRINITY LIVING CENTER #1 | 3360 UGLAND DRIVE JOLIET, IL 60432 |

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| Z 000 | COMMENTS<br><br>Annual Certification<br>Fundamental Focus Survey Extended to Full Survey | Z 000 | | |
| Z9999 | FINDINGS<br><br>Statement of Licensure Violation:<br><br>350.620a)<br>350.700a)<br>350.1210b)<br>350.1230b)7)<br>350.1230d)1)2)3)<br>350.3220f)<br>350.3240a)<br><br>Section 350.620 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.<br><br>Section 350.700 Incidents and Accidents<br><br>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.<br><br>Section 350.1210 Health Services | Z9999 | Attachment A<br>Statement of Licensure Violations | |

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following:

b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent.

Section 350.1230 Nursing Services

b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in:

7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.

d) Direct care personnel shall be trained in, but are not limited to, the following:

1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.

2) Basic skills required to meet the health needs and problems of the residents.

3) First aid in the presence of accident or illness.

Section 350.3220 Medical Care

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's

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director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

Section 350.3240 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 requirements were not met as evidenced by:

Based on observation, record review and interview, the facility failed to:

1) provide adequate health care monitoring and treatment in a timely manner for 2 of 2 (R1 and R3) in the sample who had injuries to the head and Prolonged Seizure without monitoring and medical care, including 24 hour monitoring from Skilled Healthcare Professionals when required and scheduling of specialized follow-up with a neurologist as ordered.

2) develop policies for residents' illness and injuries giving clear directives to staff to follow and implement, and provide staff teaching of protocols to follow in both urgent and emergent situations for residents and to ensure adequate supervision is in place. This has the potential to impact all residents, 14 of 14 (R4-R16, R1 and R3) residing in the facility.

3) Failed to provide treatment for urgent and emergent illnesses, monitor and follow-up on an acute illness and document changes in R1's medical condition after an unwitnessed head injury and for R3 after experiencing a prolonged

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seizure

4) Notify client's guardians of a significant incident (R1), notify the state reporting agency, Illinois Department of Public Health of unwitnessed injuries (R1) and to thoroughly investigate unwitnessed falls resulting in closed head injuries. This applies to R1 in the sample

Findings include:

According to R1's medical record and physician order sheets dated 4/1/21 and 5/1/21, R1 is a 51 year old male with several diagnoses including Down Syndrome , Bilateral Cataracts, Hip Joint Erosion, Congenital Joint Disease and Scoliosis. R1 utilize a wheelchair for transport with seat belt, walker, gait belt, shower chair and pressure relieving mattress.

Review of facility's form titled "Head Injury Observation Checklist" requires Direct Support Person to monitor resident for:

a) "after an injury to the head, the person should be monitored every two hours for 24 hours. Please fill out this form as you monitor the person, if any box is checked, please notify the nurse for further instructions. If you believe 911 is needed, please call 911 first then on call."
b) change in consciousness/confusion
c)drowsiness
d)inability to wake up call 911
e) complaints of severe pressure or pain in head
f) can they wiggle their toes and fingers. Do they complain of tingling sensation in their arms or legs
g) partial or complete loss of movement of a body

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part arms or legs. call 911
h) nausea and vomiting
i) Bruising of the head and face.
j) Blood pressure , pulse and respirations call if blood pressure over 160/100 or under 100/60, if pulse is above 100, Respirations are under 10, or above 24.

Review of facility incident report for R1 dated 4/16/21 at 5:00pm written by E12, DSP states "time reported 5:10pm" to "E10, Licensed Practical Nurse (LPN)" "R1 was found on floor in front of toilet bowl. He had a reddish blue bruise on his forehead." "medium sized bruise lump on left forehead"

E1, LPN documents on the same report, "area raised to left forehead with abrasions Refused ice no loss of consciousness. Alert respirations (blank) blood pressure 96/67 pulse 90 temperature 98.7 oxygen saturation 98% E9, Medical Doctor notified requested to monitor at (name of facility.) E19, nurse Practitioner notified requested to monitor for nausea and vomiting recheck blood pressure and increase fluids." According to report this fall was unwitnessed.

Nursing note dated 4/16/21at 5:10pm written by E10, LPN, "received call from staff ,R1 on the floor" "hit head" "left forehead with redness and abrasions" "uncooperative with pupil check" "E9 and coordinator notified" "new order to send to emergency room for nausea and vomiting. Nursing note lacked documentation of monitoring of R1's neurological status from head injury or pain management from 5:10pm until the next day on 4/17/21 at 8:30am.

Review of facility incident report for R1 dated 4/30/21 at 4pm (14 days after above fall) states,

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"fell off toilet no witness " E10, LPN documents, "4 by 3 centimeter left forehead/scalp slightly raised uncooperative with ice blood pressure 116/80 pulse 78 respirations 20 temperature 98.1 Per E9, Medical Doctor monitor him at (name of facility) for 24 hours staff instructed what to monitor for with head injury and also report any other findings.

Nursing note dated 4/30/21 at 5pm written by E10, LPN "staff reported client (R1) on floor in bathroom no loss of consciousness no active bleeding noted per staff." "nonverbal" "uncooperative with pupil check "
5:45pm E9, Medical Doctor, E19, Nurse Practitioner and E1, Director notified of incident new order received form E9, MD, staff to monitor him at (name of facility) for 24 hours staff instructed of monitoring client for signs and symptoms of head injury and signs and symptoms of fall and to monitor for any other injury."

Interview with E8, Registered Nurse Trainer on 5/3/21 at 2pm. E8 states when asked, "R1 should have gone out to the emergency room" "R1 is a fall risk. There is no safety plan in the chart that I see. The staff should monitor him during shower and toileting."

Review of Physician order Sheet (POS) dated 4/1/21 for R3 list several diagnoses including Profound Intellectual Functioning, Seizure Disorder, Cerebral Palsy, General Weakness, Left sided Leg length Discrepancy, Spinal Decompression and Degenerative Disk Disease. R3 utilize a wheelchair, built up shoe and shower chair.

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| Z9999 | Continued From page 6<br><br>Nurse note for R3 dated 4/10/21 at 9:30am unsigned by staff determined on 5/4/21 that staff is Z2, Agency Registered Nurse, "This nurse arrived at approximately 8:30am for med pass resident having Seizure sitting in chair in dining room , Certified Nurse Assistant (CNA) state had been going on since 8:15am resident shaking face tense lasted a total of 20 minutes then he was alert to surroundings no visible injuries noted morning meds given swallowed without difficulty blood pressure 149/46 pulse 76 respirations 18 temperature 99.1"<br>The nursing note failed to include notification of physician regarding R3 and/or evaluation at hospital for a 20-minute observed seizure.<br><br>Review of document requested and given by E1, Network Director on 5/10/21 titled "Basic Health and Safety taught during Preservice Week" undated, directs the staff to "call 911 when the seizures lasts longer than the individuals normal seizure or longer than 5 minutes." "Know your people and notify the nurse if they are not acting like they usually do."<br><br>Interview with E1, Section Director on 5/3/21 at 4:30pm. E1 was asked why the nurse do not utilize the hospital emergency department or urgent care when residents have illness or injuries that require immediate or emergent care. E1 states "we have been talking about the nurses making the decision on their own to send residents out to the urgent care or Emergency Room, if they need to go, without having to go through the doctor. If they feel a resident need to go, the nurse can make that determination."<br><br>Interview with E8, Registered Nurse Trainer on | Z9999 | | |

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5/4/21 at 1:30pm. E8 was asked if DSPs have trained to assess residents' neurological symptoms after a head injury. "The DSPS are not trained right now to do neuro checks. I am changing that neuro checklist."

E1, Network Director was interviewed on 5/3/21 at 2:30pm and asked for investigation for R1's injures on 4/16/21 and 4/30/21. E1 did not have investigations.

Interview with Z1, R1's guardian (brother) by telephone on 5/4/21 at 7:30am. Z1 states he was never notified by the facility of R1's falls with head injuries.

1.) R1's level of supervision remained unchanged after identified closed head injuries from unwitnessed falls. R1 never received medical care for these injuries.

2) The facility does not have written policy, procedure, protocols or guidelines defining levels of supervision which govern residents with illness and injuries.

Observations of R1 on 5/3/21 at 11:50am to 12:30pm and again on 5/5/21 at 4:48pm, sitting at the dining room table in his wheelchair. R1 has a 3 centimeter by 2.5-centimeter bruise to left forehead above parietal with various colors of yellow and green.

Observations were made on 5/5/21 4:48pm of R3 at the door of the medication room. R3 greets surveyor with a smile, did not engage in verbal communication. R3 self-propels in wheelchair.

Review of facility's document dated 9/28/20 and

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titled, "Medical Protocol : Falls and Head Injuries" requires non skilled personnel, Direct Support Person to assess a resident after a fall or head injury for the following conditions before contacting a nurse or physician:
a) receiving chemo therapy or prescribed immunosuppressive medication.
b) non - ambulatory
the
d) Diagnosis of Osteoporosis
e) the person experienced a head injury (by fall or other reason) AND they are on blood thinners and/or they have elevated blood pressure after the injury and/or they have a severe headache that does not fade or unrelieved with prescribed as needed medication.
Head Injuries
"Any further medical recommendations will occur at the discretion of a medical professional with indicated follow up by designated department staff.
The Head Injury checklist also omits directives to staff how to ascertain signs from a resident that is nonverbal and cannot express if they have pain in their head, nausea, or tingling sensation in their body.

The facility Fall and Head Injury protocol above does not give clear directives or a system to obtain medical intervention in a timely manner for residents with unwitnessed head injuries.

Review of R1's medical record on 5/11/21 at 11am failed to include a fall risk assessment or a fall safety plan by Healthcare Services.

Review of document presented to surveyor by E1, Network Director on 5/10/21 at 12:30pm. "Special Team Meeting" for R1. Team meeting included Z5, Nurse Practitioner from R1's Down Syndrome

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| Z9999 | Continued From page 9<br>Clinic. The team discussed R1's recent falls. Z5 recommend foam pads placed around toilet where R1 fall and attaching rails to toilet.<br><br>Interview with E8, Registered Nurse Trainer on 5/3/21 at 2pm. E8 states when asked, "R1 should have gone out to the emergency room" "R3 should have gone to the emergency room but I don't believe he was having a seizure that long. It is impossible. If they are having a seizure that last more than three minutes, they should be seen.<br><br>E1, Network Director was interviewed on 5/3/21 at 2:30pm and asked for notification to Illinois Department of Public Health of R1's injures on 4/16/21 and 4/30/21. E1 did not present notification.<br><br>Interview with E8, Registered Nurse Trainer on 5/4/21 at 1:30pm. E8 was asked if DSPs have trained on the requirements of the Head injury Checklist which requires Direct Support Persons to assess residents neurological symptoms after a head injury. "The DSPs are not trained right now to do neuro checks. I am changing that neuro checklist and we are going to train the staff."<br><br>Interview with E8, Registered Nurse Trainer (RNT)on 5/5/21 at 1:43pm. E8 states Z2, Registered Nurse "should have called the doctor " when R3 was having the seizure." E8, RNT also states R11 "is a picky eater, steal food and someone have to monitor him."<br><br>Interview with staff Z3 on 5/6/21 between 3p and 3:30pm. Z3 request to be anonymous due to stated concern of Managerial retaliation and losing job. Z3 states the staff schedule that | Z9999 | | |

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surveyor was given is not the correct schedule. "There are two schedules, the schedule you have there is a lot more people on there that what is on the real schedule." "R1 is left on the toilet for long periods of time and that's probably how he falls. We only have one staff on the second shift most of the time. . We have a person that comes in at 6:30pm sometimes. People come and they don't stay because we are so short. The nurses have to go through E19, Nurse Practitioner before they can even call the doctor. Residents are not sent out to the hospital. They do the photograph thing on their phones and send the photo to E9's (Medical Director) cell phone. They use their own cell phones. They send it to E9 but she never send them out."

Review of hospital emergency department (ED) record dated 11/2/20 at 7:31am for R3 states admission for Lethargy and Observed Seizure Activity. Discharge summary written by Z4, ED physician orders R3 to have a follow up with neurologist. Record review as of 5/10/21 shows no evidence R3 have seen neurologist (6 months after order)

The nursing note failed to include notification of physician regarding R3 and/or evaluation at hospital for a 20-minute observed seizure.

Interview with E8, Registered Nurse Trainer on 5/4/21 at 1:30pm. E8 was asked if DSPs have trained to assess residents' neurological symptoms after a head injury. "The DSPS are not trained right now to do neuro checks. I am changing that neuro checklist." E8 was asked what should staff have done during and after R3's

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seizure. E8 states "the DSP should call the team van and take to (name of local hospital and if seizures call 911. " an agency nurse was working when R3 had the seizures "she should have called 911 if he was having seizure over 3 minutes, the staff knows."

Interview by telephone on 5/10/21 at 3pm with E8, Registered Nurse Trainer (RNT). E8, RNT was asked when was the last time E9, Medical doctor (MD) went to the facility to assess residents who have injuries or illnesses. E8 ,RNT states the last time "I went with her (E9, MD) was the end of January this year" E8 (RNT) states E10, Licensed Practical Nurse will document "some things in the resident chart and some things in a booklet she keep in the home." E8 was asked how does the information in the booklet of resident medical information get passed along to other healthcare personnel involved in that resident's care if it is not documented in the chart. E8, (RNT)states E10 (LPN) will leave a sticker of the resident problem she would like E8, Nurse Trainer to check, inside the medicine cart "and I know to look there."

Interview with E8, Registered Nurse on 5/11/21 at 2:45pm. E8 states the new protocol for head injuries and other emergencies or resident illness that require immediate attention is the staff "will call the nurse or Doctor as soon as possible so they (residents) can be seen in Emergency Room if the hospital sends them back the nurse will be instructed to do neuro checks until the end of the shift. The Direct Support Person is to call 911 if there is an emergency or life threatening then E9, Medical Director.

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