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	IL6016497	A. BUILDING: _____ B. WING _____	C 12/13/2021

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S 000	Initial Comments Complaint Investigation 2198791/IL140701 Investigation of Facility Reported Incident of 11-28-21/IL141111	S 000		
S9999	Final Observations Statement of Licensure Violations: (Findings 1 of 2) 300.610a) 300.1210b) 300.1210d)3) 300.1220b)2) 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 b) The facility shall provide the necessary care	S9999	**Attachment A** Statement of **Licensure Violations**	

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S9999	Continued From page 1 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: 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. 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 as evidenced by:	S9999		

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S9999	Continued From page 2 Based on observation, interview, and record review, the facility failed to assist a resident with gaining access to vision services by failing to make requested appointments and arrange for transportation. This failure affected one (R1) of four residents reviewed for vision services. This failure resulted in R1 becoming depressed and feeling socially isolated and worthless as a result of not being able to participate in activities due to poor vision. Findings include: R1 is a 67 year old female who has resided in the facility since 2018 with the following past medical history: Lumbosacral root disorder, not elsewhere classified, Type 2 diabetes mellitus without complications, morbid (severe) obesity due to excess calories, unspecified lack of coordination, Candidiasis unspecified, weakness, major depressive disorder, and low back pain. On 12/07/2021at 11:30AM, R1 was observed in her room, awake, alert and oriented x3. R1 stated that she is upset because the facility took a year and a half to schedule her for a needed eye appointment/surgery as recommended by facility ophthalmologist in 2018. R1 stated she finally got an appointment in March of 2021, got to the clinic and was told that the doctor does not work there anymore. R1 stated she paid $200.00 in transportation for the appointment. R1 continued to state that she finally saw an eye doctor on 6/7/2021, who stated that she is almost blind in her right eye. At that time, R1 made a follow-up appointment and informed the facility staff, but they forgot to arrange for transportation, so she missed that appointment (which was in August 2021) and has not been rescheduled for another one since. R1 said that she feels hopeless and	S9999		

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S9999	Continued From page 3 worthless because she cannot participate in activities because she cannot see. R1 stated, "Right now, I can't even see your face, just a shadow." Per R1, her social worker wasn't doing much and R1 was just assigned a new social worker in November. Review of physician order summary for R1 shows an order for resident to see Ophthalmologist at a hospital dated 11/08/2018. Review of physician progress notes for R1 document various statements of R1's concern and feelings about her vision dating back to 11/25/2020. Review of social service progress notes also show several documentations that R1 feels bad and does not feel good about herself due to her bad sight, dating as far back as 12/05/2020. On 12/08/2021 at 12:08PM, V7 (Social Service Director) said that nurses make the arrangements for resident appointments, and the scheduler arranges for transportation. V7 said that she is not aware that R1 missed her doctor's appointment due to transportation; V7 recalls R1 telling her that V7 was informed of an appointment but V7 forgot to tell the staff. V7 said that she educated R1 on the importance of telling staff about upcoming appointments and that V7 mentioned it to nursing. V7 further stated V7 was not sure who V7 told in particular and not sure if V7 wrote a progress note either. On 12/08/2021 at 12:30PM, V5 (Scheduler) said that R1 does not have any scheduled appointments; he only arranges for transportation and the nurses usually schedule the appointment, then inform him. On 12/09/2021 at 2:42PM, V8 (Social Worker)	S9999		

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S9999	Continued From page 4 said that she has worked on and off with R1, but R1 was never on her caseload; V8 only covers when R1's assigned social worker is not available. V8 stated that for the small period she worked with R1, R1 was concerned with going home and having a cataract surgery but V8 does not handle resident appointments; nurses do that. Documentation by a psychiatrist assistant dated 9/20/2021 includes: R1stated her frustration. R1 missed her eye appointment due to lack of transportation, staff said she never told them about the appointment, but it has been rescheduled. On 12/09/2021 at 12:46PM, V7 (Social Service Director) stated that she does not know which staff was told of appointment and could not find any documentation of the appointment being rescheduled. V7 added that she agrees that someone dropped the ball; the appointment should have been rescheduled and the resident should have been informed of what was going on. Surveyor requested a facility policy and/or protocol related to scheduling of appointments for residents, but none was provided during the course of this survey. (B) (Findings 2 of 2) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3)	S9999		

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S9999	Continued From page 5 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. 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 300.1220 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,	S9999		

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S9999	Continued From page 6 and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as 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 monitor and supervise a resident who is a known fall risk per care plan. This failure affected one (R4) of four residents reviewed for accidents. This failure resulted in R4 having a fall that required emergent transfer to the hospital, where she was diagnosed with an acute nondisplaced fracture of the bilateral nose. Findings include: R4 is a 76 year old female who has resided in the facility since 6/26/2021 with past medical history including: Unspecified sequelae of cerebral infarction, Alzheimer's disease, Schizophrenia, cognitive communication deficit, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, disorientation, dysphagia oropharyngeal phase, weakness, unsteadiness on feet, etc. On 12/08/2021at 3:30PM, R4 was observed in the dining room with other residents. R4 was sitting in a wheelchair and tearing off her incontinence brief. Large pieces of the brief were observed on top of the table by R4. No staff were close to R4 or monitoring R4. Surveyor continued	S9999		

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S9999	Continued From page 7	S9999		

to observe R4 for 10 minutes before a staff noticed what R4 was doing and then took R4 to change her incontinence brief.

R4's care plan dated 4/26/2021 includes that R4 is at risk for falls. The care plan states: Resident had a fall on 6/19/2021, 6/24/21, 7/10/21, 8/31/21 r/t Impaired Cognition. Interventions included: Bilateral floor mats when in bed, monitor at all times when in wheelchair and not in bed, observe frequently and place in supervised area when out of bed, place on early morning get up list. Another section of the same care plan states that R4 had a fall with injury on 6/20/21. Interventions included wheelchair for locomotion, frequent visual checks, occupy resident with meaningful distractions, etc.

Facility Minimum Data Assessment (MDS) dated 10/01/2021 section G (Functional status) has R4 coded as 3/2 for all ADLs (Activities of Daily Living) which indicates that R4 requires extensive assist with one person physical assist.

On 12/09/2021 at 1:46PM, V12 (Restorative Certified Nursing Assistant/CNA) stated that the day R4 sustained the injury to her nose (11/28/21) she (V12) had gotten to work around 8:00am and was informed that R4 was found on the floor. V12 was not working directly with R4 but helps with monitoring in the dining room. V12 stated R4 uses a wheelchair and has an unsteady gait due to stroke. V12 added that R4 requires constant supervision and extensive staff assistance with ADLs.

On 12/09/2021 at 2:17PM, V13 (Licensed Practical Nurse/LPN) said that (11/28/21) she (V13) got to work at around 7:10AM the day that R4 had her injury, and she did not see anything;

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S9999	Continued From page 8 R4 was already on her way out (to the hospital) when V13 came in. The night shift nurse reported to V13 that she was doing rounds when she noted R4 with blood on her nose. R4 returned from the hospital on V13's shift with a swollen nose, but it was no longer bleeding, R4 denied pain and vital signs was stable. V13 received a report from the hospital that resident had a fractured nose, she reported to DON (Director of Nursing) and also called the family. V13 said that she has worked with R4 for a few months and (R4) requires extensive care with ADLs, constant supervision and was on a get up list for overnight shift. V13 added that residents on the early get up list are usually up and in the nursing station by the time morning shift gets to work. R4 does not use a walker or bed alarm but has an electronic monitoring device. On 12/09/2021 at 3:10PM, V15 (LPN) said that she was the assigned nurse for R4 on 11/28/21; V15 was passing meds and around 6:30am while coming back from another resident's room, V15 saw R4's roommate with a sheet covered in blood. V15 entered the room and saw R4 in her bed with blood, asked R4 what happened and R4 could not answer. V15 asked the roommate, who said that she does not know, she just trying to help out. V15 assessed R4, vitals were okay, R4 denied pain but V15 could not stop the bleeding. V15 called the doctor and got an order to send resident out to the hospital. V15 also notified the family and the DON. V15 added that that was her first time working with R4; the only thing they told her was that R4 tries to get up by herself. V15 stated she did not receive any report of R4 requiring constant monitoring and/or supervision. V15 added that the last time she saw R4 was around 4:45am when V15 gave R4 her medication.	S9999		

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S9999	Continued From page 9 Review of R4's POS (Physician Order Summary) for the month of November 2021 does not include any orders for medication to be given during the night shift; there are orders for two medications to be given as needed. Review of MAR (Medication Administration Record) for November 2021 does not include documentation that R4 received any scheduled or as needed medications on 11/28/21 (per V15's statement) or at any other time during the month of November 2021. There is no documentation in R4's medical record to show that a visual check was performed as care planned from the evening of 11/27/21 - 11/28/21 when R4 had the fall with injury. (B)	S9999		