STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007918	A. BUILDING: _____ B. WING _____	C 12/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF RICHTON PARK REHAB & NS(	22660 SOUTH CICERO AVENUE RICHTON PARK, IL 60471

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S 000	Initial Comments Complaints Investigations: 2199286/IL00141332 2199010/IL00140969 2198823/IL00140735 2199095/IL00141095 2199414/IL00141506 Facility Reported Investigation (FRI) to Incident of 11/15/21/IL141078 Facility Reported Investiation (FRI) of 12/8/21/IL141393	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 3) 300.610)a 300.1210b) 300.1210d)6) 300.1220b)2) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 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: 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,	S9999		

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S9999	Continued From page 2 discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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 Requirements were Not Met evidencded by: Based on interviews and records reviewed the facility failed to follow their abuse policy and prevent a resident-to-resident physical attack. Against 1 of 3 (R2) residents reviewed for physical abuse and failed to follow its abuse policy and prevent an incident of staff to resident verbal abuse for 1 of 3 R9 residents reviewed for verbal abuse. This failure resulted in R2 being physically assaulted by R1, R1 hit R2 over the head and in the face resulting bleeding from the face, a swollen bruised left eye. Based on interviews and records review, the facility neglected to provide incontinence care for more than 8 hours to one resident (R3) who is dependent on care for ADL's. This failure effected one resident (R3) of three residents reviewed for abuse/neglect. This neglectful act resulted in R3 verbalizing she felt abused and abandoned by the facility staff. Findings include:	S9999		

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S9999	Continued From page 3 A.R1 is a 28-year-old with diagnosis including, but not limited to Schizophrenia, Depressive Disorder, Anxiety, Psychosis, Bipolar, and Delusional Disorders. R1's medical history includes Nursing Facility Placement Assessment Summary dated 10/5/20 notes R1 had physical aggression, violence, and agitation. R1 physically attacked a nurse unprovoked. R2 is a 50-year-old with diagnosis including, but not limited to Schizoaffective Disorder, Depressive Disorder, and Anxiety Disorder. On 12/14/21 at 12:20PM R1 said she has gotten into more than one fight with residents. R1 said "I cracked" R2 over the head and left her bleeding on the floor. On 12/14/21 at 12:30PM V6, Certified Nursing Assistant (CNA), said R1 has mental issues. V6 said she has seen R1 throw meal trays. On 12/14/21 at 12:38PM V4, Licensed Practical Nurse, said R1 is known to fight with other residents for nothing. V4 said R1 is sometimes angry, and we don't know why she is angry. V4 said he saw R2 after her altercation on 11/15/21 with R1. V4 said he saw R1 had black, dark color, discoloration under half her eye from the corner outward. V4 said R1 said R2 hit her. On 12/14/21 at 1:46PM V7, Social Service Director, said R1 and R2 had an altercation on 11/15/21 resulting in R1 sustaining a black eye. V7 said R1 has had altercations with other residents. On 12/14/21 at 2:21PM V8, Social Services, said R1 has had physical altercations with other	S9999		

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S9999	Continued From page 4	S9999		

residents. V8 said when one resident hits another resident it is abuse.

On 12/15/21 at 10:34AM V18, CNA, said she was working on the unit with R1 and R2. V18 said she saw R1 hit R2. V18 said after R1 hit R2 she had a scratch over her left eye, and she was bleeding. V18 CNA said she was not given instructions when starting the shift with R1 related to interventions for behavior. V18 said she did not know R1 could be aggressive towards other residents. During a second interview at 12:15PM V18 said neither R1 nor R2 had been on one to one supervision prior to the incident on 11/15/21.

On 12/15/21 at 11:18AM R2 said she was punched in the head and face by R1. R2 said she tried to talk to R1 and R1 kept walking away from R2. R2 said when she turned to walk away she tripped on her feet and fell. R2 said R1 then started hitting her. V18 said after being attacked the right side of her head was bleeding, she had contusions and bruises over her left eye and face.

On 12/15/21 at 11:59AM V7 said R1 and R2 have had a previous physical altercation with each other.

On 12/15/21 at 12:07PM V3, Quality Assurance Nurse, said on 8/3/21 R1 threw coffee at R2. V3 said following this incident R1 and R2 were separated to live on different floors. V3 said when R2 got hit on 11/15/21 both R1 and R2 were residing on the same floor.

On 12/15/21 at 12:39PM V2, Director of Nursing, said she would separate residents involved in physical alterations by moving them onto separate floors. V2 said after an altercation resident should be on one-to-one supervision to

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S9999	Continued From page 5 ensure the safety of the other residents. On 12/15/21 at 1:20PM V17, CNA, said residents should not be hit by other residents. On 12/15/21 at 1:48PM V15, CNA, said she was assigned to work the floor where R1 and R2 had a physical altercation on 11/15/21, but she was not on the floor when the altercation happened. V15 said she did not know that R1 and R2 had had an altercation in the past. V15 said before R1 has a behavior outburst she can see her become tense. V15 said no residents were on one to one on the floor on 11/15/21 prior to the altercation. On 12/16/21 at 9:14AM V1, Administrator, said she investigated R1's and R2's altercation from 8/3/21 as a potential abuse investigation. V1 said the investigation did not substantiate abuse had occurred but the residents were separated by moving R2 to another floor. V1 said regarding R1's and R2's physical altercation investigation on 11/15/21 abuse was substantiated. V1 said the residents were residing on the same floor again, because one of the residents had requested to return to the floor. V1 said R1 and R2 are living on separate floors now. On 12/17/21 via phone interview V26, Doctor, said if there is bad blood between residents, such as a history of fighting or aggression towards each other, it would not be prudent to put residents in the same place. V26 said it was not a wise decision to place R1 and R2 on the same floor. R1 incident reported dated 5/12/21 notes R1 initiated physical aggression. Incident report dated 8/3/21 notes R1 threw liquid at R2. Incident	S9999		

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S9999	Continued From page 6 report dated 11/15/21 notes R1 made physical contact with R2. The facility incident date report 11/15/21 notes R1 made contact with R2. The Abuse Prevention Program revised 01/2019 states It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitations, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. Facility reported incident documents the following: It was reported that housekeeping staff V23 allegedly acted inappropriate towards Resident R9. Conclusion: The CNA staff overheard poor customer service being communicated towards resident R9. Based on findings the allegations were substantiated disciplinary actions taken. R9's social service progress note dated 12/8/2021 documents: Resident reported he was ok and the housekeeper was rude and verbally inappropriate. On 12/15/201 at 12:06 PM V5 (Housekeeping supervisor) states V22 (housekeeper) went to clean R9's room and she didn't knock on the door. He told her that and she had an attitude. V5 states a CNA witnessed V22 call R9 a name. On 12/15/2021 at 2:17 PM V23 (CNA) states it was after breakfast and he heard V23 (housekeeper) curse at R9 and say to R9 "I don't care about this f****** job. You can report me if you want." On 12/16/2021 at 11:40 PM R9 states, "the situation with the housekeeper (V22) was she	S9999		

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was rude. She came in my room and turned on the light and didn't even knock on the door. I was just waking up and I asked her to come back in 10 minutes. She said, "I'm going you "fat M* F*" and as she was walking out, she said "I can't stand that "fat M* F*." R9 states one of the staff heard her. R9 states V23 always had an attitude. R9 states regarding V23, "she hurt my feelings. I felt disrespected and angry."

R3's ADL Care plan documents: R3 has a Self-Care Deficit: Requires extensive to total assist with ADL's to maintain highest possible level of functioning as evidenced by the following limitations and potential contributing diagnoses; cerebral infarction, lack of coordination, and weakness. May resist ADL care at times. Last revision on 10/28/2020.

MDS section GG dated 9/30/2021 documents on admission resident required: Partial to moderate assistance with Toileting.
Staffing schedule for 12/14/2021 document 3 CNA's on the 3rd floor V11, V13, and V14. V26 (RN) states she was assigned to R3 on 12/14/2021.

On 12/15/2021 at 1:22 PM R3 states "I'm tired of begging staff to help me. I don't have a CNA every day or they didn't know they were assigned to me. R1 states, yesterday (12/14/2021) she didn't get her depends changed all day until 4:30 PM. R3 said, first they told me it was V14. V14 stated it was V11 (CNA). V11 never came to the room. R3 states, "I'm persistent on my light and no one came to help me change until 4:30 PM. There was no supervisor. I requested a supervisor and they said she was in a meeting and was busy." On12/17/2021 at 1:58PM, R3 states "I felt abandoned and abused because I

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S9999	Continued From page 8 can't help myself. I know it's not supposed to be like that." Staffing schedule for 12/14/2021 document 3 CNA's on the 3rd floor V11, V13, and V14. V26 Registered Nurse (RN) states she was assigned to R3 on 12/14/2021. On 12/15/2021 at 2:03 PM outside 1st floor conference room. V26 (RN) states she did not clean or help clean R3 on 12/14/2021. V26 states the CNA's clean the resident's up but the nurses will assist if needed. V26 states, she was R3's assigned nurse on 12/14/2021 for the day shift. On 12/15/2021 at 2:04 PM V13 (CNA) states she did not have R3 yesterday and did not change her. On 12/15/2021 at 2:05 PM V14 (CNA) states V14 states she worked on the 3rd floor during the 1st shift, but R3 was not assigned to her. V14 states R3 requires assistance with incontinence care. V14 states she cleaned R3 up during the evening shift. V14 states was told to clean R3 up. V14 states, she didn't see R3 before that. I did not change her during the day shift. When I changed R3, she told me she had not been changed all day. On 12/15/2021 at 2:51 PM V11 (CNA) states R3 didn't want me to care for her. R3 called me a devil. V11 states she did not change her during the shift. V11 states, she did not ask R3 if she needed anything. Surveyor askes V11, "Did you ask someone to check on R3 during your shift?" V11 states, "Yes, I did, a supervisor from another floor checked on her. I don't know the name of the supervisor because I'm new. I don't know everyone yet."	S9999		

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S9999	Continued From page 9 On 12/22/2021 at 11:50 AM V1 (Administrator) states it is her expectation that if R3 refuses care from one person then the facility would find someone else to help her. V1 states "a couple months ago this started, and she went a couple days without anyone caring for her." The facility's Abuse Prevention Program Policy dated 1/2019 documents the following: it is the policy of the facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and crime against a resident in the facility. Facility's Activities of Daily Living Routine Care Policy and Procedure documents the following: Residents are given routine daily care and HS care by a C.N.A or Nurse to promote hygiene, provide comfort and provide a homelike environment. ADL care is provided throughout the day at intervals that are coordinated between the care giver and the resident. "B" (2 of 3) Statement of Licensure Findings: 300.610a) 300.1210a)b) 300.1210d)5) 300.1220)b)2)3)	S9999		

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S9999	Continued From page 10 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 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	S9999		

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S9999	Continued From page 11 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: 5)A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 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 3)Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs	S9999		

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S9999	Continued From page 12 and goals to be accomplished, physician's orders, 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 evidencded by: Based on observation, interview and record review the facility failed to follow their practice for pressure injury prevention, and turn and reposition a resident every two 2 two hours, and failed to develop an individualized plan of care for off-loading a wound. This affects 1 of 3 residents (R8) reviewed for pressure injury. This failure resulted in R8 wound continued to worsen and developing necrosis that required surgical intervention of debridement. Findings include: R8 face sheet shows R8 has diagnosis of respiratory failure, hypoxia dependent of ventilator, tracheostomy status, gastrostomy status, encephalopathy, seizure disorder, atherosclerotic heart disease, hypertension, contracture of joint, cardiac arrest, reduced mobility, and venous thrombosis. R8 MDS (Minimum Data Set) dated 09/29/21 shows R8 requires extensive assist and two plus person	S9999		

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S9999	Continued From page 13 physical assist with bed mobility. Section C shows R8 rarely/ understood. Section M for skin condition shows R8 has a one stage 3 pressure ulcer/ injury and one stage 4 pressure ulcer/injury. On 12/14/21 at 11:39am V33 (R8 Family) said R8 is not turned every two hours and R8 has a pressure ulcer. V33 said the wound doctor informed her that R8 wound is getting better but she does not have details about R8's wound. V33 said R8 did not have the wound to the right thigh prior to admission to the facility. On 12/15/21 at 11:39 R8 was observed resting in bed, R8 observed resting on air mattress in static position, R8 has gastric tube feeding running at rate of 75militers hour, R8 observed to have tracheostomy connected to a ventilator. R8 was not alert. R8 is laying on her back, with lower body (hips, thighs, knees) resting to the right side. R8 was observed with a rolled cloth resting between R8 knees, and also a rolled cloth resting under R8 right knee. R8 has heel protector boots bilaterally. At 12:32p.m V29 (Nurse) provided wound care to R8's right thigh (back), R8 was observed to have a large wound to the back of R8's right thigh, the wound had 2 openings, the wound bed was observed with pink, tannish and faint black tissue, surrounding skin appeared to be R8's skin tone. After the wound care treatment, V29 placed R8 back in the same position at 12:42p.m. When V29 and V6 (Restorative Aide) turned R8, R8 was observed to be contracted in a fixed position, (there were no obvious range of motion observed). At 1:59p.m V11 (CNA-Certified Nursing Aide) said she was going to provide care to R8 with assist of V14 (CNA).	S9999		

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S9999	Continued From page 14 At 2:02p.m when surveyor entered R8 room, V6 (Restorative Aide) said she was finished providing care and stated she repositioned R8. R8 was observed in the same position. V6 lift the sheet to allow for observation of R8's position, R8 was observed resting on her back, with hips and knees resting to the right side, R8 had a rolled cloth between the knees and a rolled cloth under her right knee. R8 was observed resting in the same position that that she'd been in since 11:39a.m. During this wound care observation, and review of R8's TAR and POS, R8 received wound care according to physician orders. On 12/16/21 at 1:15pm V11 (CNA) said she was the aide assigned to R8 on 12/15/21 on the 7:00am-3:00pm shift. V11 said residents are supposed to be turned and repositioned every two hours, V11 said turning and repositioning takes the pressure off the residents, and if the residents are not turned and repositioned the residents can get pressure ulcers. V11 said the resident position should change otherwise "that's not repositioning". On 12/15/21 at 9:30am V9 (Wound Care Director) said if a resident cannot turn themselves, they should be turned and repositioned every two hours, V9 said 2 to 10 minutes is not enough time to allow for pressure relief to a wound, V9 said pressure relief should be for two hours. V9 (Wound Care Director) said the facility does not have a turn and reposition program, and that he checked that box because there were no other options for him to choose from for turning and repositioning. V9 said R8 is completely immobile and unresponsive and R8 requires assistance with turning and repositioning. V9 said the Braden review is completed to determine the residents risk for	S9999		

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S9999	Continued From page 15 pressure ulcers and the care plan is completed based on the risk identified. R8 progress note dated 03/19/2020 shows in-part new admit, 41 year old from SNF, and eyes open, nonverbal, tracheostomy to ventilator. G-tube intact. BLE (bilateral lower extremities) contracted, with right great toenail discolored, no exudate, no swelling, surrounding skin intact, has open wound to right lateral ankle, no s/s of infection. MD (medical doctor) notified, new tx (treatment) order received, documented and provided to site. See wound assessment for further details. Spoke to resident mother and informed her of resident skin alterations, treatments and interventions in place and that d/t (due to) R8 diagnosis and comorbidities she is at risk for wound deterioration and/or acquiring new wounds. R8 mother verbalized appreciation and understanding of the information received. Resident on low air-loss mattress. Has BLE (bilateral lower extermity) heel protectors. Kept clean, dry, and repositioned every 2 hrs. Moisture barrier applied per incontinent episode. R8 wound evaluation and management dated 12/14/21 completed by V48 (wound care Physician), shows in part Site 1, stage 4 pressure wound of right thigh full thickness, etiology; pressure, stage;4, duration; 223 days, objective; healing, wound size is 11.2 centimeters in length by 4.9 centimeters in width by 3.1 centimeters in depth, surface area of 54.88 centimeters squared, undermining; 3 centimeters at 12o'clock position, moderate exudate, 10% thick adherent devitalized necrotic tissue, 90% granulation tissue, wound progress is improved, 10% thick adherent devitalized necrotic tissue, 90% granulation tissue, primary dressing treatment; gentamicin ointment apply once daily	S9999		

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S9999	Continued From page 16 for 7 days: alginate calcium apply once daily for 16 days, secondary dressing -gauze island with boarder apply once daily for 16 days, and peri wound- skin prep apply once daily for 16 days. Site 2, wound right medial first toe full thickness, 1 day duration, objective; healing, surface area 1.15centimeters, moderate exudate, 100% granulation tissue. Plan of care reviewed and addressed; recommendations are to off load wound; reposition per facility protocol; sponge boot. Surgically excise 5.49 centimeters squared of devitalized tissue and necrotic muscle and surrounding fascial fibers were removed at a depth of 3.2 centimeters and healthy bleeding tissue was observed. R8 weekly wound evaluation dated 12/7/21 shows in-part site- right thigh rear (35), pressure ulcer(pre-admission), stage 4, 11centimeters in length by 2 centimeters in width by 3.5 centimeters in depth, wound identified on 7/18/21, wound not healed, pain management in place, no tunneling, yes for undermining at 3 o' clock position, no sinus tract, exudate-serous, moderate, thin watery and foul, wound bed-non verbal, does not hurt, and is warm to touch, tissue type-90% granulation, 0% slough, and 10% necrotic, wound color is pink, yellow and red, peri wound is defined, with surrounding tissue is warm, comments- cleanse with NSS (normal saline), apply gentamicin ointment, loosely pack with alginate and skin prep with peri wound then cover with boarder gauze island dressing daily, treatment date 11/16/21, other interventions are pressure redistribution mattress, specific turning/repositioning program, nutritional supplements, vitamins, positioning devices, protein supplements, heel boots, low air loss mattress, wound debrided today, current wound status-seen today by wound doctor during weekly	S9999		

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S9999	Continued From page 17 routine rounds at the facility. This site noted with improvement, no odor, resident on IV ABT (intravenous Antibiotics) family and physician notified, care plan reviewed and updated. R8 wound management summary (procedure summary) dated 12/21/21 shows in-part, surgically excise 3.92 centimeters squared of devitalized tissue and necrotic muscle and surrounding fascial fibers were removed at a depth of 3.2 centimeters and healthy bleeding tissue was observed. R8 wound management summary (procedure summary) dated 07/27/21 shows in-part, surgically excise 13.00 centimeters squared of devitalized tissue and necrotic muscle and surrounding fascial fibers along with slough and biofilm were removed at a depth of 0.4 centimeters and healthy bleeding tissue was observed. R8's plan of care with initiated date of 04/13/2020 shows R8 has an alteration in skin integrity and is at risk for additional and/or worsening of skin integrity issues related to impaired cognition/communication, incontinence of bladder/bowel, impaired mobility status, impaired nutritional status, vent and tract due to respiratory failure, and obesity. Location(s): 5/3/21 Right thigh (pressure ulcer), 7/20/21 right lateral ankle (pressure ulcer) (Healed 10/8/21), and 7/20/21 right distal 1st toe (paronychia) (Resolved 8/10/21). See the weekly skin notes for site, stage, measurements, progress, etc. Date Initiated: 05/03/2021 Created on: 04/10/2020. Revision on: 10/14/2021. The goal is R8's wound will show improvement as evidence by S/S (sign and symptoms) of healing thru next review unless the disease process causes further unavoidable deterioration. R8 will be free of any additional skin	S9999		

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S9999	Continued From page 18	S9999		

integrity issues, unless the disease process causes further unavoidable deterioration thru next review. Interventions- every day shift for wound care cleanse right great toenail with NSS (normal saline), pat dry and apply triple ABT (antibiotic) ointment then cover with dry dressing daily and PRN (as needed) if dressing becomes loose/soiled, skin will be checked during routine care on a daily basis and during the weekly/biweekly bath or shower schedule.
Any skin integrity issues/concerns will be conveyed to the Charge Nurse for further evaluation and/or treatment changes/new interventions and the MD (medical doctor) will be called PRN. Pressure reducing/relieving mattress and W/C (wheel chair cushions) cushion as needed.
Weekly measurements and documentation and monitor for S/S of infection and report to MD (medical doctor) as indicated.

On 12/23/21 at 10:45am V2 (Director of Nursing) said care plan's are individualized to the resident needs, and the care plan are update as needed.

Care Plan for R8 skin alteration plan of care does not address turn, reposition and off-loading R8's wound to the right thigh.
R8 Braden review dated 10/28/21 shows Braden score of 8 (very high risk) for pressure ulcer development). Assessment type (other) Sensory perception unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. Or limited ability to feel pain over most of body surface. Constantly moist skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned. Bedfast: Confined to bed. Mobility -Does not make even slight changes in body or extremity

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S9999	Continued From page 19 position without assistance. Nutrition (adequate) - Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered or is on a tube feeding or TPN regimen which probably meets most of nutritional needs. Friction /sheer (problem) - Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction. Facility policy Titled "Care Planning and Procedure" with last update of 04/2017 shows in-part each resident will have a comprehensive assessment completed that will assist in the development of an individualized plan of care that will include goals and interventions aimed to improve or maintain the resident highest level of function, prevent decline, decrease risk of complications of medical conditions, medication and diagnosis, decrease risk of injury or to promote comfort at end of life. The resident has the right to unless adjudged to be incompetent or otherwise found to be incapacitated under the law of the state, participate in planning care and treatment changes in care and treatment. The facility must have evidence that the resident and/or responsible party was afforded the opportunity to participate in care planning. It is the policy of the facility to assist residents to participate. Each resident will have a comprehensive assessment complete by the Interdisciplinary team upon admission, quarterly and with significate changes and an individualize care plan will be developed and updated as needed with quarterly assessments,	S9999		

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S9999	Continued From page 20 readmissions and changes in condition. Facility policy Titled "Wound Management Program" date 05/19/2017 shows in part the purpose of the wound management program to ensure our residents have access to the appropriate assessment and management in the prevention and treatment of pressure injuries and other wounds in accordance with clinically accepted guidelines to improve quality of life for all resident in our care and to improve residents outcomes and maximize health and quality of life by using evidence based wound care principles through a cost effective standardized process. Risk and assessment- the purpose of this policy is to establish consist and objective method of assessing the residents risk for pressure injury development and to implement a standardized plan of pressure injury prevention based upon reliable and valid assessment of pressure injury risk. Pressure Injury Prevention- it is the policy of this facility to implement measurements to protect the resident's skin integrity and prevent skin breakdown whenever possible. The purpose of this policy is to establish and provide consistent measures for the prevention of pressure injuries based upon the assessment of pressure injury risk. The procedure shows this facility will implement interventions based upon the results of the skin risk assessment. Resident who are unable to turn and reposition independently will be assisted to turn and reposition every two hours or as appropriate. Etiology of the wound- a pressure injury is a lesion caused by unrelieved pressure that results in damage to the underlying tissue. Wound Cleansing and Dressing-It is the policy of the facility to perform wound dressing changes as ordered by the physician using clean technique on all chronic or contaminated wounds. A moist wound environment is most favorable for	S9999		

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S9999	Continued From page 21 optimal healing. On 12/21/21 at 5:27pm V48 (Physician) said a resident should be turned and repositioned every two hours, and every two hours are standard practice from CMS and the national pressure injury advisory panel recommendation. V48 (Physician) said 2 to 10 minutes is not enough time for off laoding, and the standard is 2 hours for off loading. V48 said it is her expectation that the residents are turned and repositioned very two hours to allow for off-loading of the wound. V48 said when a pressure wound is not offloaded (relieved of pressure) it causes lack of oxygen to the tissue, which in turnscause the tissue to become necrotic. V48 said necrotic tissue has to be debrided. V48 said debriding is not a bad thing because it expose viable tissue to promote wound healing. V48 said if a resident is not turned and repositioned to wound off-loaded every two hours, it contributes to impeding wound healing. V48 said there are 3 factors that contribute to impeding wound healing, which are pressure, lack of oxygen, and biofilm. V48 said a lack of oxygen causes the tissue to die and become necrotic, biofilm cause bacteria (which contribute to infection) and pressure is micro injuries. V48 (Physician) said on July 27, 2021, R8 stage 2 wound was debrided to reveal a stage 4 pressure injury. V48 acknowledge that alginate calcium with silver was ordered on 07/20/21 to promote wound healing, V48 said it is her expectation that the treatment orders are implemented. V48 said alginate calcium with silver is an absorbent (of exudate), antimicrobial, and debriding wound treatment.	S9999		

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S9999	Continued From page 22 "B" (3 of 3) Statement of Licensure Findings: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)2) 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. 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	S9999		

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S9999	Continued From page 23 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: 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. 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)	S9999		

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S9999	Continued From page 24 These Requirements were Not Met evidencded by: Based on interview and record review the facility failed monitor the g-tube site to prevent an avoidable accident while providing direct care to 1 of 3 resident (R12) reviewed for avoidable accidents. This failure resulted in the g-tube becoming dislodged during incontinence care requiring R12 to be sent to the local hospital to have the g-tube replaced. Based on interviews and records reviewed the facility failed to effectively monitor and supervise a resident with a history of aggressive behaviors for 1 of 3 residents (R1) reviewed for supervsion. This failure resulted in R1 striking a co-resident (R2) over the head and in the face resulting in brusing and swelling to R2's left eye. Findings include: 1. R12 diagnosis include hemiplegia affecting the right side, encounter for gastrostomy. R12 progress notes dated 9/29/21 shows resident g-tube (gastric tube) observed dislodged from abdomen. Resident is currently on a pureed diet with honey thicken liquids with a good appetite usually consumes 100% of meals and fluids. V46 (Physician) made aware. Order for a 3 day calorie count put in place. Nursing staff will continue to monitor. V46 gave order to send resident to emergency room for g-tube replacement. On 12/22/21 at 1:45pm V14 (CNA) said on 9/29/21 during incontinent care, R12 gastric tube was accidently pulled out when she turned R12 and to remove the soiled linen from under R12. V14 said she did not look and make sure R12	S9999		

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S9999	Continued From page 25 gastric tube was in a position so that it would not get pulled out. V14 said she should have checked and made sure the gastric tube was out of the way, during care, so that the tube is not pulled out. V14 said she immediately reported this to the director of nursing at that time. V14 said she remember that R12 had to go to the hospital after his g-tube was pulled out. V14 restated that it was an accident. On 12/23/21 at 10:45am V2 (Director of Nursing-DON) said the aide/nurse should make sure make they observe the position of the g-tube before initiating care, turning and repositioning, so that they can know where it is and before doing care, they should ensure the g-tube is secure and out of the way so that the g-tube is not pulled out and or dislodged. V2 said the gastric tube is delicate and it can be pulled out causing discomfort. V2 said if the tube is pulled out the resident would have to have it replaced. On 12/22/21 at 2:00pm V3 (Quality Assurance Nurse) said she remember something about R12 gastric being pulled, and the DON at that time doing an inserve with the aides. V3 presents an in-service dated 9/29/21 showing the aides were in-service on ensuring all g-tube are properly labeled per MD orders, G-tube site monitored for any s/s (signs / symptoms of infections, and ensuring all residents with g-tubes are safely repositioned and g-tube visible during care. V14 and V47 (CNA) name is not noted on the in-service training staff education document. 2. R1 is a 28 year old with diagnosis including, but not limited to Schizophrenia, Depressive Disorder, Anxiety, Psychosis, Bipolar, and Delusional Disorders. R1's medical history	S9999		

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	IL6007918	A. BUILDING: _____ B. WING _____	C 12/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF RICHTON PARK REHAB & NS(	22660 SOUTH CICERO AVENUE RICHTON PARK, IL 60471

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S9999	Continued From page 26 includes Nursing Facility Placement Assessment Summary dated 10/5/20 notes R1 had physical aggression, violence, and agitation. R1 physically attacked a nurse unprovoked. R2 is 50 year old with diagnosis including, but not limited to Schizoaffect Disorder, Depressive Disorder, and Anxiety Disorder. On 12/14/21 at 12:20PM R1 said she has gotten into more than one fight with residents. R1 said "I cracked her (R2) over the head and left her bleeding on the floor." R1 said she hit R2 because R2 threw a chair at her. On 12/14/21 at 12:38PM V4, Licensed Practical Nurse, said R1 is known to fight with other residents for nothing. V4 said R1 is sometimes just angry and we don't know why she is angry. V4 said he saw R2 after her altercation on 11/15/21 with R1. V4 said he saw R1 had black, dark color, discoloration under half her eye from the corner outward. V4 said R1 said R2 hit her. On 12/14/21 at 1:46PM V7, Social Service Director, said R1 has had altercations with other residents. V7 said she did not witness the altercation. On 12/14/21 at 2:21PM V8, Social Services, said R1 has had physical altercations with other residents. V8 said he did not witness the altercation. On 12/15/21 at 10:34AM V18, CNA, said she was working on the unit with R1 and R2 on 11/15/21. V18 said the altercation happened across from the nurses' station. V18 said she saw R1 on R2, R1 was hitting R2. V18 said she did not see what provoked R1. V18 said after R1 hit R2 she had a	S9999		

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S9999	Continued From page 27	S9999		

scratch over her left eye and she was bleeding. V18 said she did not know R1 could be aggressive towards other residents. During a second interview at 12:15PM V18 said she did not see or hear a chair having been thrown. V18 said neither R1 or R2 had been on one to one supervision prior to the incident on 11/15/21.

On 12/15/21 at 11:18AM R2 said she was punched in the head and face by R1. R1 said she had thrown a chair at R2 because R1 kept walking away when R2 tried to talk to her. R1 said when she turned to walk away she tripped on her feet and fell. R1 said R2 then started hitting her. V18 said after being punched the right side of her head was bleeding, she had contusions and bruises over her left eye and face.

On 12/15/21 at 11:59AM V7 said R1 and R2 have a history of physical aggression prior to 11/15/21.

On 12/15/21 at 12:07PM V3, Quality Assurance Nurse, said on 8/3/21 R1 threw coffee at R2. V3 said following this incident R1 and R1 were separated to different floors. V3 said when R2 got hit on 11/15/21 R1 and R2 were residing on the same floor.

On 12/15/21 at 12:39PM V2, Director of Nursing, said after an altercation residents should be on one to one supervision to ensure the safety of the other residents. V2 said the sound of a chair being thrown should cause staff to react because a chair being thrown is a warning that something is about to happen.

On 12/15/21 at 1:48PM V15, CNA, said she was assigned to work the floor where R1 and R2 had a physical altercation on 11/15/21, but she was not on the floor when the altercation happened.

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S9999	Continued From page 28 V15 said she did not know that R1 and R2 had had an altercation in the past. V15 said no residents were on one to one on the floor on 11/15/21 prior to the altercation. On 12/16/21 at 9:14AM V1, Administrator, said she investigated R1's and R2's altercation from 8/3/21 as a potential abuse investigation. V1 said the residents were separated by moving R2 to another floor. V1 said regarding R1's and R2's physical altercation investigation on 11/15/21 abuse was substantiated. V1 said the residents were residing on the same floor again, because one of the residents had requested to return to the floor. On 12/17/21 via phone interview V26, Doctor, said if there is bad blood between residents, such as a history of fighting or agression towards each other, it would not be prudent to put residents in the same place. V26 said it was not a wise decision to place R1 and R2 on the same floor. R1's incident report dated 5/12/21 notes R1 initiated physical aggression. Incident report dated 8/3/21 notes R1 threw liquid at R2. Incident report dated 11/15/21 notes R1 made physical contact with R2. R1 facility census dated 10/4/21 notes R1 was moved to the same floor as R2. The facility incident date report 11/15/21 notes R1 made contact with R2. R1's care plan date initiated 11/26/20 notes 10/05/20 per PASSR screen R1 has several arrests for property damage, aggravated battery, assault with deadly weapon, and verbally threatening to shoot a policy officer.	S9999		

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S9999	Continued From page 29 R1's care plan date initiated 5/20/21 notes difficulty controlling anger and depression, feelings of paranoia, loss of control, misinterpretation/misperception secondary to mental illness. Interventions include staff will redirect behavior. R1's care plan initiated 11/26/20 notes R1 displays conflictual, difficult behavior as manifested by covert/open conflict with or repeated criticism of staff. Conflict/anger toward family/friends, unprovoked expressions of anger towards staff and peers. These behaviors are related to poor and ineffective coping skills and psychiatric illness. The Abuse Prevention Program revised 01/2019 states It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitations, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. "B"	S9999		