STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005961	A. BUILDING: _____ B. WING _____	12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD NURSING & REHAB CENTER	152 WILMA DRIVE MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.675a) 300.675b) 300.675c) 300.675d) 300.675e) Section 300.675 COVID-19 Training Requirements EMERGENCY a) Definitions. For the purposes of this Section, the following terms have the meanings ascribed in this subsection (a): 1) "CMMS Training" means CMMS Targeted COVID-19 Training for Frontline Nursing Home Staff and Management, available at https://QSEP.cms.gov. 2) "Frontline clinical staff" means the medical director of the facility, facility treating physicians, registered nurses, licensed practical nurses, certified nurse assistants, psychiatric service rehabilitation aides, rehabilitation therapy aides, psychiatric services rehabilitation coordinators, assistant directors of nursing, directors of nursing, social service directors, and any licensed physical, occupational or speech therapists. Any consultants, contractors, volunteers, students in any training programs, and caregivers who provide, engage in, or administer direct care and services to residents on behalf of the facility are also considered frontline clinical staff. 3) "Management staff" means any facility staff who:	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 A) Assign and direct nursing activities; B) Oversee comprehensive assessment of residents' medical needs and care planning; C) Recommend numbers and levels of nursing personnel; D) Plan nursing service budgeting; E) Develop standards of nursing practice; ILLINOIS REGISTER 19565 20 DEPARTMENT OF PUBLIC HEALTH NOTICE OF EMERGENCY AMENDMENT F) Supervise in-service education and skill training for all personnel; or G) Participate in the screening of prospective residents and resident placement. b) Required Frontline Clinical Staff Training 1) All frontline staff employed by facilities shall complete the following portions of CMMS Training: A) Module 1: Hand Hygiene and PPE; B) Module 2: Screening and Surveillance; C) Module 3: Cleaning the Nursing Home; D) Module 4: Cohorting; and E) Module 5: Caring for Residents with Dementia in a Pandemic. 2) Facilities shall ensure at least 50% of frontline clinical staff have completed the CMMS Training by December 31, 2020. 3) Facilities shall ensure 100% of the frontline clinical staff have completed the CMMS Training by January 31, 2021. 4) Facilities shall require, within 14 days after hiring, CMMS Training for all frontline clinical staff hired after January 31, 2021. c) Required Management Staff Training 1) All management staff employed by facilities shall complete the following portions of CMMS Training: A) Module 1: Hand Hygiene and PPE; B) Module 2: Screening and Surveillance; ILLINOIS REGISTER 19566 20 DEPARTMENT	S9999		

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S9999	Continued From page 2 OF PUBLIC HEALTH NOTICE OF EMERGENCY AMENDMENT C) Module 3: Cleaning the Nursing Home; D) Module 4: Cohorting; E) Module 5: Caring for Residents with Dementia in a Pandemic; F) Module 6: Infection Prevention and Control; G) Module 7: Emergency Preparedness and Surge Capacity; H) Module 8: Addressing Emotional Health of Residents and Staff; I) Module 9: Telehealth for Nursing Homes; and J) Module 10: Getting Your Vaccine Delivery System Ready. 2) Facilities shall ensure at least 50% of management staff have completed the CMMS Training by December 31, 2020. 3) Facilities shall ensure 100% of management staff have completed the CMMS Training by January 31, 2021. 4) Facilities shall require, within 14 days after hiring, CMMS Training for all management staff hired after January 31, 2021. d) By December 31, 2020, all facilities shall certify compliance, in the form and format specified by the Department, with subsections (b)(2) and (c)(2). e) By January 31, 2021, all facilities shall certify compliance, in the form and format specified by the Department, with subsections (b)(3) and (c)(3). (Source: Added by emergency rulemaking at 44 Ill. Reg. 19551, effective December 2, 2020, for a maximum of 150 days) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete the required CMMS Targeted COVID-19 Training for Frontline Nursing Home Staff and Management Staff. This had the	S9999		

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S9999	Continued From page 3 potential to affect all 81 residents living in the facility. Findings include: On 12/09/2021 at 10:47 AM, V1, Administrator, stated that she has completed the Attestation statement for the CMMS COVID training. On 12/9/21 at 1:43 PM, V3, Licensed Practical Nurse, (LPN), stated that she has not done the QSEP (CMMS COVID training) training and she has no idea what it is. On 12/9/21 at 1:45 PM, V1 stated that she does not see the certificate for V3. On 12/9/21 at 1:55 PM, V9, LPN, stated that she has not taken QSEP training (CMMS COVID training). On 12/9/21 at 3:10 PM, V1 stated, "Both (V3 and V9) have not done the QSEP (CMMS COVID training). I am not sure how they got missed. We are having them do it now." On 12/13/2021 at 11:50 AM, V1, Administrator, presented an email verification dated 07/18/2021 at 9:57 AM sent to dph.providers@illinois, documented that on 7/15/2021 that she certified that 100% of the "Frontline clinical staff" and 100% of the "Management staff" of the facility had completed the "CMMS Targeted COVID-19 Training for Frontline Nursing Home Staff and Management." The Resident Census and Conditions of Residents, CMS 672, dated 12/06/2021, documents there are 81 residents living in the facility.	S9999		

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S9999	Continued From page 4 (C) 300.1210b) 300.1210c) 300.1210d)6 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. 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. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to create and implement appropriate interventions to prevent falls and injuries and perform safe transfers for 4 of 6 residents(R44, R59, R61, R182) reviewed for	S9999		

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S9999	Continued From page 5 incidents/accidents in the sample of 52. This failure resulted in R182 sustaining a fall that resulted in a left hip fracture requiring hospitalization and surgical repair. R182 subsequently had an additional fall that resulted in dislocation of the left hip fracture. Findings include: 1. R182's Care Plan, start date: 11/24/2021 and last reviewed/revised: 12/07/2021 01:52 PM documents, Category: Falls PROBLEM: I have experienced an actual fall 11/21/21, 11/29/21. It also documents Approach: 12/07/2021 Resident receiving a low bed, and therapy to evaluate due to fall. 11/27/2021 IDT (interdisciplinary team) to review my fall and provide interventions as indicated. 11/24/2021 Complete post fall assessments and monitoring per facility protocol. Notify my provider if any COC (change of condition) is observed. 11/24/2021 Provide me with follow up care as indicated r/t (related to) my injury until healed. 11/24/2021 remind me to use call light for assistance. R182's Progress Note, dated 11/21/2021 at 11:31 AM, documents, "resident walking in hallway when he fell onto floor landing on left hip. resident was wearing 2 different shoes unequal in height. did not hit head. resident able to move extremities, assisted into w/c (wheelchair) then into bed with 2 assist supporting weight to left leg. resident c/o (complain of) pain 10/10 to left hip. educated resident to stay in bed. expresses understanding. call placed to (area ambulance) for transport to (local) er (emergency room). poa (power of attorney) notified. np (nurse practitioner) notified. don (Director of Nursing) notified."	S9999		

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S9999	Continued From page 6 R182's Progress Note, dated 11/21/2021 at 5:31 PM, documents, "resident admitted to (local) hospital with left hip fx (fracture). don notified. updated poa." R182's Progress Note, dated 11/23/2021 at 1:05 PM, documents "IDT: FALL IDT team will evaluate for fall intervention when resident returns to facility." R182's Progress Note, dated 11/24/2021 at 5:49 PM, documents, "resident arrived back to facility from (local) hospital at 5:35pm via ambulance and two emts (emergency technicians). resident alert to self with confusion, eyes perrl (pupils equal, round, reactive to light), mouth in fair condition, lcta (lungs clear to auscultation), no sob (shortness of breath) or distress noted, o2 (oxygen) sat (saturation) 98% on RA (room air), bowel sounds present x4, lbm (last bowel movement) 11/22/21. scar noted to abdomen, (dressing) in place to left hip, not to be removed until post op day 7. resident denies any pain at this time. resident denies any pain or distress at present time, orders faxed to pharmacy, md (physician) notified of arrival, will monitor." R182's Focused Observation, dated 11/24/21, documents R182 cognitive status is confused and requires re-orientating to surroundings. R182's Progress Note, dated 11/24/2021 at 9:56 PM, documents, "[Recorded as Late Entry on 11/27/2021 03:57 PM] IDT: FALL resident had a fall before hospitalization which resulted in fracture. resident was educated to use call light for assistance upon return from hospital and will be evaluated by therapy for possible further interventions"	S9999		

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S9999	Continued From page 7 R182's Progress Note, dated 11/29/2021 at 6:20 PM, documents, "Resident found on floor at 0615pm. Laying on right hip. Unable to states if he's in pain. EMS (emergency medical service) called to transport to ER. (V20, Physician) and family notified." R182's Progress Note, dated 11/30/2021 at 12:46 AM, documents, "Spoke with RN (Registered Nurse) at (local) Hospital. Resident admitted to hospital for dislocation of left hip. Administrator and DON notified. Family to be notified in the AM." R182's Progress Note, dated 12/06/2021 at 3:46 PM, documents, "Resident returned back to facility via ambulance. Resident denies pain or distress. Left hip surgical site with redness noted with mild drainage. area clean. bruises noted to resident's bilateral arm r/t IV's. Residents' vitals 119/65 137 99% 76 97.5. covid restrictions in place. resident states he is very tired and weak. will continue to monitor." On 12/7/2021 R182 stated that he didn't know how he fell one day he was here then the next he was there. R182 attempted to use call light, upon request, without success. Resident was unable to locate the call light and when given to him stated that he didn't know what to do with it. On 12/6/2021 at 4:00 PM, R182 calling out for help and moving about the bed. Call light not on. On 12/8/21 at 8:30 AM, R182 calling out for help and moving about the bed. Call light not on. On 12/8/21 at 8:50 AM, R182 calling out for help and moving about the bed. Call light not on. On 12/8/21 at 9:06 AM, R182 calling out for help	S9999		

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S9999	Continued From page 8 and moving about the bed. Call light not on. On 12/8/21 at 9:30 AM, R182 calling out for help and moving about the bed . Call light not on. On 12/8/21 at 9:30 AM, R182 calling out for help and moving about the bed. Call light not on. On 12/8/21 at 9:41 AM, R182 calling out for help and moving about the bed. Call light not on. On 12/8/21 at 10:00 AM, R182 calling out for help and moving about the bed. Call light not on. On 12/8/21 at 1:50 PM, R182 calling out for help and moving about the bed. Call light not on. On 12/9/2021 at 10:15 AM, R182's was sitting in room in reclining wheelchair, foot pedals not in place, near door. R182's call light on floor next to chair. R182 fidgeting with clothing. R182's Progress Note, dated 12/09/2021 10:31 AM, documents, "this nurse called to resident room by cna (certified nurses aide), upon entering room resident sitting on his bottom in front of his (reclining) chair leaning toward his right side. resident asked was he hurting anywhere and resident shook his head no, upon assessment no further injuries noted, resident denied pain to bilateral hips or legs, neurochecks wnl (within normal limit). resident asked what happened and how did he end up on the floor, resident unable to give a clear answer, resident stated 'a lot of things happened' and mumbled a few words. resident given education r/t safety and reminded to use call light for assistance. resident assisted to bed x3 assist and made comfortable, call light in reach. (V21) notified and nor (new order) to send resident to ER to be evaluated."	S9999		

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S9999	Continued From page 9 On 12/9/21 at 12:30 PM V2, Director of Nursing (DON), stated that R182 requires more supervision. V2 stated that they are putting more interventions in place. V2 stated that they are going to move him closer to the nurses station so he could be monitored more closely. On 12/9/21 at 12:45 PM V8, Registered Nurse (RN), stated that R182 has been different since returning from breaking his hip. V8 stated that he is more confused and requires more supervision than before. V8 stated that R182 had some confusion before but he is more confused now. V8 stated that if R182 wasn't on isolation, he would be sitting at the nurses station to be monitored. V8 stated that the area around the nurses station is where residents that require increased supervision are placed so they can be monitored. V8 stated that (R182) is one of these residents. On 12/15/2021, V20, Physician, stated that the facility may have went by R182's previous status and didn't feel that he needed more. V20 stated that it is tricky with supervision for residents because of COVID. V20 stated that the residents that are positive have to be quarantine. V20 stated that the facility still has to take care of them. The Facility Fall Risk Assessment Policy, dated March 2018, documents, Policy Interpretation and Implementation. 6) Assessment data shall be used to identify underlying medical condition that may increase the risk of injury from falls. 9) The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of the risk factors that are not	S9999		

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S9999	Continued From page 10	S9999		

modifiable. Fall Risk Factors 1) f. footwear that is unsafe or absent. Resident-Centered Approaches to Managing Falls and Fall Risk; 5) If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. Monitoring Subsequent Falls and Fall Risk 1) The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 4. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.

2. On 12/08/2021 at 8:45AM, V4, Certified Nurse Assistant (CNA), placed gait belt on R44. V4 had a hold of R44's gait belt with her left hand and her right elbow was under R44's right armpit. Then V4, CNA and V15, CNA lifted R44 out of his reclining geriatric chair, with V4 pulling up on R44's armpit. His bilateral knees were bent, and his feet were not touching the floor while he was being lifted into his bed.

R44's Care Plan, dated 06/07/2021, documents that R44 requires 1 to 2 assist with transfers.

R44's Minimum Data Set (MDS), dated 11/24/2021, documents that R44 requires extensive assist of 2 staff members for weight bearing support for transfers. It also documents that R44's balance during surface-to-surface transfer activity did not occur.

R44's Face sheet, dated 12/09/2021, documents diagnoses of Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disorder, Type 2

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S9999	Continued From page 11 diabetes. On 12/09/2021 at 8:30 AM, V18, CNA Supervisor, stated that she expected the CNA's to use the gait belt appropriately and not to lift the resident under their armpits. On 12/08/2021 at 9:30 AM, V2, Director of Nurses, stated that she would expect the CNA's to utilize the gait belt appropriately and not to lift up underneath a resident's armpit. V2 also stated that she would have therapy assess (R44) for a full mechanical lift. 3. R59's Care Plan updated 10/19/21, documents "(R59) has experienced an actual fall on 09/04/2019. Interventions: Provide me with a low bed." It continues "(R59) is at risk for falling related to incontinence. Interventions: Provide toileting assistance every 2 hours and as needed, Keep call light in reach at all times, and Keep personal items and frequently used items within reach." It continues "(R59) has a self-care deficit related to inability to walk. Interventions: Dependent on one staff for dressing, and required one staff assist with personal hygiene and oral care." It continues "(R59) is unable to dress or groom independently related to cognitive deficit. Interventions: Utilize assistive devices as indicated." R59's MDS dated 10/8/21, documents, (R59) has a severe cognitive impairment and is totally dependent on two staff for bed mobility, toileting and bathing. R59 requires extensive assistance from two staff for transfers. On 12/8/21 at 11:15 AM, V10, CNA, and V11, CNA, were assisting R59 from her bed to her wheelchair using a full body mechanical lifting	S9999		

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S9999	Continued From page 12 device. R59 was already lying on the lift device's sling, V11 attached the four straps of the sling to the lift and failed to check if the straps were secured prior to lifting R59 off the bed. V11 operated the lift device while V10 was holding the wheelchair. R59 was swinging freely as she was moved from her bed around to her wheelchair located towards the foot of her bed, without either CNA having constant contact with her. R59 was screaming during the movement. Both CNA's then held R59 as she hovered over the wheelchair and lowered into the chair. On 12/9/21 at 9:35 AM, V9, Licensed Practical Nurse (LPN), stated "If we are transferring a resident using the mechanical lift, we should be gloving up, attach the lift to the sling under the resident and lift the resident up. One person is operating the lift while the other person is guiding the resident's feet while putting them down." On 12/9/21 at 11:15 AM, V2, DON, stated, "I would expect staff to maintain contact with the resident at all times when using a mechanical lift." The facility's policy "Lifting Machine, Using a Mechanical" dated 7/2017, documents "Attach sling straps to sling bar: Make sure the sling is securely attached to the clips and that it is properly balanced. Check to make sure the resident's head, neck and back are supported. Before resident is lifted, double check the security of the sling attachment. Examine all hooks, clips, or fasteners. Check the stability of the straps. Ensure that the sling bar is securely attached and sound. Lift the resident two inches from the surface to check the stability of the attachments, the fit of the sling and the weight distribution." It continues "Gently support the resident as he or she is moved, but do not support any weight."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005961	A. BUILDING: _____ B. WING _____	12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD NURSING & REHAB CENTER	152 WILMA DRIVE MARYVILLE, IL 62062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13	S9999		

4. R61's Care Plan dated 4/21/21, documents, "(R61) is unable to transfer independently due to generalized weakness. Interventions: Utilize assistive devices as indicated in program, explain procedure to (R61), provide gait belt with transfers, place gait belt firmly around waist, place walker in front of him, (R61) to rock back and forth to gain momentum, then aid to a standing position, when stable (R61) to stand for as long as tolerated, (R61) to turn and pivot, praise when task is accomplished, lock wheelchair brakes prior to transfer, encourage to use arms when pushing up from chair, and encourage not to rise fast, take time and get bearing prior to standing."

R61's MDS, dated 10/11/21, documents (R61) has a severe cognitive impairment and required assistance from two staff members for transfers. It continues (R61) is always incontinent of both bowel and bladder.

On 12/6/21 at 10:15 AM, V4, CNA, was assisting R61 from his wheelchair to his bed for incontinence care. V4 left the room to get a gait belt, returned and placed the belt around R61's abdomen loosely and did not tighten it prior to helping him up. V4 then assisted R61 to stand by holding onto his shoulder and arm and did not use the gait belt. V4 then assisted R61 to his bed.

On 12/9/21 at 9:22 AM, V3, LPN, stated, "If we are transferring a resident using a gait belt, we are supposed to place the belt around them, under the breast line, and tighten enough to be able to insert two fingers under the belt. We hold the belt with both hands, then guide and assist the resident up."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005961	A. BUILDING: _____ B. WING _____	12/15/2021

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S9999	Continued From page 14 On 12/9/21 at 11:25 AM, V17, CNA, stated, "If I'm using a gait belt, I make sure it is placed around the resident's waist, tighten it where I can only fit a couple fingers under it, then use both hands and help the resident get up. I like to use two people when I have to lift someone like that." On 12/9/21 at 11:14 AM, V2, DON, stated "I would expect staff to use the gait belt properly at all times while transferring a resident." The facility's policy "Gait Belt" undated, documents "Gait belts will be used by all employees in the transfer and ambulation of residents who require assistance. Belt may be loosened when not in use." It continues "Always use the gait belt when the resident requires "hands on" assistance to ambulate or transfer. Always place belt around resident's waist over soft tissue and never over ribs, hip bones or breasts. Always have belt applied snugly so there is not possibility of it sliding up on ribs." It continues "Chair to bed transfer: Apply gait belt. Lock/secure chair and bed. Move resident to edge of chair. Move toward unaffected side. Assist resident to standing position. Have resident pivot or turn toward bed. Assist resident to sitting position at edge of bed (guide with belt and good body mechanics)." (A)	S9999		