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
	IL6001457	A. BUILDING: ______ B. WING ______	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN URBANA NRSG & REHAB	302 WEST BURWASH SAVOY, IL 61874

(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 Complaint Investigations: 2266828/IL150575 2267008/IL150790	S 000		
S9999	Final Observations Statement of Licensure Violation 1 of 5: 300.610a) 300.690a) 300.1210b) 300.1210d)6) 300.3240c) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of	S9999	Attachment A 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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that resident.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care 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 300.3240 Abuse and Neglect

c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act)

These Regulations are not met as evidenced by:

Identified failures require more than one deficient practice statement.

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A.) Based on interview and record review the facility failed to ensure R52, R64, and R88 were not to subjected mental, verbal, and physical abuse by R46. This failure puts these residents at risk for severe, life threatening, and potentially fatal injuries. R46, R52, R64 and R88 are four of seven residents reviewed for abuse in the sample list of 99.

Findings include:

The facility's Abuse Prevention Program policy with an effective date of 11/28/17 documents, "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents." "Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability." "Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention (77 Ill. Adm. Code 300.330). Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (42 CFR 483.12 Interpretive Guidelines)." "Pre-Admission Screening of Potential Residents. The facility shall check the criminal history background on

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S9999	Continued From page 3 any resident seeking admission to the facility in order to identify previous criminal convictions." "For residents who are identified offenders, the facility shall incorporate the Identified Offender Report and Recommendation Report into the identified offender's plan of care including the security measures listed." "Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of resident including, but not limited to, the separation of the residents." R46's Face Sheet dated 8/19/22 documents an admission date of 6/18/22. R46's Admission Minimum Data Set (MDS) dated 6/27/22 documents diagnoses including Schizophrenia, Wernicke's Encephalopathy, Alcohol Abuse with Intoxication and Unspecified Mood Disorder. This MDS documents a BIMS (Brief Interview for Mental Status) score of 9/15 indicating moderately impaired cognition. R46's Care Plan dated 6/20/22 documents R46 has a history of criminal behavior and documents a care plan updated 8/26/22 that since admission R46 has had some aggressive behaviors towards others with interventions to promote safety, intervene when inappropriate behavior is observed. This Care Plan documents R46 is a wanderer and (R46) goes in other resident's rooms and can be difficult to redirect with a revision date of 6/27/22. R46's Nurse's Notes in June 2022 documents R46 curses and yells at residents and staff and	S9999		

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goes into other residents' rooms and gets agitated and does not want to leave easily.

R46's Nurse's Notes in July 2022 documents R46 was physically and verbally abusive to staff.

R46's Nurse's Notes in August 2022 continue to document verbal abuse and being combative with staff.

R46's Nurse's Note dated 8/26/22 at 2:55 PM, documents R46 was sent to a Psychiatric hospital.

R46's Nurse's Note dated 8/26/22 at 4:20 PM documents R46 was being issued a 30-day discharge notification due to recent incidents and behaviors which were affecting other residents.

a.)1.) The facility's Preliminary Incident Investigation Report dated 8/19/22 at 12:20 PM, documents (R46) were ambulating in (R46's) wheelchair behind (R52) and (R64). (R46) said "f*** you" (expletive) and (R64) responded by saying the same to (R46). (R46) then propelled (R46's) wheelchair towards (R52) and (R64) and they fell to the ground. The residents were separated, and (R46) is being monitored 1:1 (one to one) pending orders received for (R46) to be sent out for evaluation. Following nurse assessments of the residents, no injuries were noted for any of the three residents. Residents will be monitored for signs and symptoms of distress. Physicians and POAs (Power of Attorneys) were notified.

R46's Nurse's Note dated 8/19/22 at 12:20 PM, R46 became agitated with two other female residents (R52, R64). R46 was in a wheelchair on R46's way back from the dining room. (R52 and

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R64) were ambulating back from lunch. R46 was heard yelling F*** you to (R52 and R64). One of the female residents yelled F*** you back to R46. R46 sped up the wheelchair and hit (R52 and R64) directly knocking them to the ground. R46 stated that they deserved it, they shouldn't talk to R46 like that. R46 on 1:1 supervision from time of incident.

On 9/1/22 at 9:42 AM, V14 LPN (Licensed Practical Nurse) stated V14 witnessed R46 run R46's wheelchair into R52 and R64 on 8/19/22 and knock them to the ground. V14 stated V14 heard bickering and cuss words being yelled and V14 saw R46 plow R46's wheelchair towards R52 and R64 and knock them to the ground. V14 stated when R52 and R64 were on the ground they were yelling cuss words at R46 and calling R46 a SOB (Son of a B****) (expletive). V14 stated V14 separated R46, R52 and R64. V14 stated V14 asked R46 why R46 knocked R52 and R64 down and R46 told V14 that they were making fun of R46 and R46 told V14 that R46 would do it again. V14 stated R46 stayed with V25 Social Services Director after the incident.

R52's Order Summary Report dated 8/30/22 documents diagnoses including Major Depressive Disorder, Cerebral Infarction and Unspecified Dementia without Behavioral Disturbance.

R52's Nurse's Note dated 8/19/22 at 12:20 PM, documents fall was witnessed and occurred in the hallway. R52 was ambulating back from the dining room and the reason for the fall was evident. Another resident knocked R52 over. R52 was ambulating down the hallway and a male resident (R46) yelled F*** you and R52 yelled it back. This prompted (R46) to speed toward R52 in R46's wheelchair knocking R52 to the ground.

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V14 LPN/writer witnessed the fall. No head trauma. Parties separated. Nursing Assessment completed. Vital signs recorded. No complaints of pain. Able to move all extremities. Assisted to standing with two assists. Able to ambulate back to room without difficulty.

R52's BIMS Evaluation dated 8/19/22 documents a score of 9/15 indicating moderately impaired cognition.

R64's Order Summary Report dated 8/30/22 documents diagnoses including Alzheimer's Disease, Unspecified Dementia with Behavior Disturbances and Anxiety Disorder.
R64's Nurse's Note dated 8/19/22 at 2:05 PM, documents at 12:20 PM R64 was ambulating back to room from dining room, talking with roommate. Another male resident (R46) became agitated, yelled F*** you at R64, R64 yelled it back. This prompted R46 to speed toward R64 in R46's wheelchair knocking R64 to the ground. V14/writer witnessed fall. No head trauma. Parties separated. Nursing assessment completed. Vital signs recorded. No complaints of pain. Able to move all extremities. Assisted to standing with two assists. Able to ambulate back to room without difficulty. Primary Care Provider notified. POA notified.

R64's BIMS Evaluation dated 8/19/22 documents a score of 3/15 indicating severely impaired cognition.

a.)2.) The facility's Preliminary Incident Investigation Report dated 8/30/22 documents the incident happened on an unknown date. (R88) stated another resident (R46) "called me a f***ing b**** (expletives) and double fist hit my nose so bad" around a month ago.

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R88's Order Summary Report dated 8/31/22 documents diagnoses including Transient Cerebral Ischemic Attack and Repeated Falls. This Order Summary documents an order for Clopidogrel (Plavix/Anticoagulant) 75 mg (milligrams), one tablet by mouth once a day related to Cerebral Infarction with a start date of 5/18/21.

R88's Nurse's Note dated 8/30/22 at 2:50 PM, documents (R88) reported to Administrator (V1) that "a month or so ago, another resident called me F---in b---- and double fist hit my nose so bad". (R88) reported that (R88) still felt pain on (R88's) nose bridge every now and then from the alleged incident.

R88's BIMS Evaluation dated 7/14/22 documents a score of 10/15 indicating moderately impaired cognition.

On 8/30/22 at 11:12 AM, during resident council meeting, R32 reported there was a physical altercation R32 witnessed that occurred between two residents in R32's room but asked to identify the residents and details in private.

On 8/30/22 at 12:20 PM, (R32) requested the State Survey Agency come with R32 to R32's room after resident council meeting finished at this time. R32 stated R46 "punched (R88) right in the face." R32 stated R32 witnessed this occur as it occurred right inside the doorway to R32's room. R32 stated R88 and R32 were in R32's room talking when R46 entered the doorway of R32's room. R32 stated R88 asked R46 to please move so R88 could leave R32's room and that is when R46 punched R88 with a closed fist. R32 stated R88's "glasses went flying across the floor" in R32's room and R88 started crying. R32 stated

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S9999	Continued From page 8 R46 got very hostile when this happened. On 8/30/22 at 1:25 PM, (R88) stated the picture the State Survey Agency showed R88 was R46. R88 stated R46 called R88 a "fat f***ing b*****" (expletives) a "few different" times. R88 stated around a month ago, R46 hit R88 so hard across the nose that R88 glasses fell off R88's face. R88 stated R88 "hurt so bad" and R88 was experiencing headaches and dizziness that R88 still gets from time to time since R46 hit R88. R88 stated R88 developed a little bruising to R88's nose. R88 stated R88 started crying and was afraid that R46 would come at R88 again. R88 stated, "nothing would surprise (R88) with what (R46) could or would do to anyone" in the facility. At this time R88 became tearful and began sobbing and crying again. R88 stated the facility "would be stupid to ever let that f***ing a**hole (expletives) back in." R88 stated, "(R88) just wants to feel safe." 8/30/22 at 1:41 PM, (R32) stated R32 is, "very much so afraid of (R46)" and that R46 "has a bad temper." On 8/30/22 at 1:55 PM, (R88) began crying when discussing R46 hitting R88 across the nose. R88 stated R46 "doubled up (R46) fist" and hit R88 right across the nose. R88 stated, "(R88) never hurt so bad" as R88 did after R46 hit R88 with a closed fist. R88 stated it felt like R88's nose was split in half and R88's nose began bleeding after R46 hit R88. R88 stated R88 notified the staff nurses who R88 could not identify. R88 stated R88 nose still bleeds a little from time to time when R88 blows it. R88 stated staff had even taken stuff to clean R88's blood from R88's nose. R88 stated R88's nose still hurts. R88 agreed to go to the hospital for testing and/or radiology	S9999		

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testing if the doctor says R88 needs to. On 8/30/22 the facility provided a list of interviewable residents on the second floor of the facility which also indicates all of the residents that could potentially be affected by R46's aggressive behavior.

B.) Based on interview and record review the facility failed to prevent a resident-to-resident altercation for two (R89, R95) of seven residents reviewed for abuse in the sample list of 99.

Findings include:

b.)1.) The facility's Abuse Prevention Program dated November 28, 2017, documents: "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. Abuse is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish."

The facility's Final Incident Investigation Report dated 9/2/22 documents the following: On 8/28/22 staff observed R95 attempt to inappropriately touch another resident R89. V12 Certified Nursing Assistant (CNA) initially reported that V12 witnessed R95 touch R89 on R89's private (genital) area. V12 intervened and separated R95 from R89. V12 later clarified to local police that R95 was attempting to grab and unbutton R89's pants, and R89 was shaking and pushing R95 away with both of R89's hands. R95's hands were touching and grabbing towards R89's private (genital) area.

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S9999	Continued From page 10 R95's undated Diagnosis List documents R95 has diagnosis of Bipolar Disorder. R95's Minimum Data Set (MDS) dated 8/3/22 documents R95 has severe cognitive impairment, requires supervision of one staff person for locomotion on R95's unit. R95's Care Plan revised on 5/5/22 documents R95 has the potential to be physically aggressive towards other residents and has a history of a physical altercation with another resident. R95's Care Plan revised on 5/31/22 documents R95 has a behavior problem of exposing R95's self in R95's room and inappropriately touching female staff. This care plan includes an intervention "Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed." R95's Nursing Note dated 10/22/2021 at 11:51 PM documents R95 appeared in the common area wearing only an incontinence brief and shirt. R95 was asked what R95 was doing and replied that R95 "wanted some." R95 was told that R95 was inappropriate and redirected back to R95's room. R95's Nursing Note dated 8/28/2022 at 2:24 PM documents R95 was touching a female resident (R89) and trying to unbutton her pants. R89's undated Diagnosis List documents R89 has a diagnosis of Alzheimer's Disease. R89's MDS dated 8/1/22 documents R89 is rarely/never understood, has short- and long-term memory impairment, R89's Care Plan dated 6/17/22 documents R89 is at risk for abuse and neglect per the facility's assessment tool. R89's Nursing Note dated 8/28/2022 at 2:39 PM documents R89 was sent to the hospital for evaluation after R89 was touched in groin area by another male resident (R95).	S9999		

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S9999	Continued From page 11 On 8/29/22 at 3:56 PM V22 Licensed Practical Nurse (LPN) stated: R95 has made sexual comments to staff and residents while passing them in the hallway. R95 would say things such as "you can come sit on my lap, or I'll help you undo your pants." This has been an ongoing behavior. We try to keep a close eye on R95 and have R95 near the nurse's station. R95 does wander at times. On 8/30/22 at 9:38 AM V12 CNA stated: On 8/28/22 around 1:50 PM, R95 was in the television room facing the window, and R89 was facing the television. R95 had R89's hands on R89 trying to unbutton R89's pants. R89 is nonverbal. R89 used R89's hands to try and push R95's hands off of R89, while R95 continued to attempt to unbutton R89's pants. V12 immediately separated R95 from R89. R95 is confused, and during incontinence care has made sexual comments in regards to female staff's breasts. On 8/31/22 at 3:30 PM V39 LPN stated: About a month ago during shift change, V39 saw R89 and R95 in the television room. R95's back was facing V39, and R95's arm was near R89. V39 was not able to see R95's hands. V39 approached R95, and R95 "acted startled" and said "I'm not doing anything." "It (the situation) didn't sit well with me (V39)." R95 and R89 were immediately separated. V39 reported the incident to V13 Previous Administrator, and V13 told V39 "it sounds like two residents with Dementia." After that incident, whenever V39 worked V39 had the female residents sit in the hallway for monitoring. R95 required close supervision. (B)	S9999		

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300.1010h)
300.1210a)
300.1210b)
300.1220b)3)
300.2040b)2)
300.2050

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 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for

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CHAMPAIGN URBANA NRSG & REHAB	302 WEST BURWASH SAVOY, IL 61874

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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 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.

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,

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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.

Section 300.2040 Diet Orders

b) Physicians shall write a diet order, for each resident, indicating whether the resident is to have a general or a therapeutic diet. The attending physician may delegate writing a diet order to the dietitian.

2) The diet shall be served as ordered.

Section 300.2050 Meal Planning

Each resident shall be served food to meet the resident's needs and to meet physician's orders. The facility shall use this Section to plan menus and purchase food in accordance with the following Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to timely identify and address significant weight loss, complete thorough nutritional assessments, and implement physician ordered nutritional recommendations for four (R13, R70, R95, R63) of 12 residents

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reviewed for nutrition in the sample list of 99. These failures resulted in R13 sustaining a severe weight loss of 6.11 % in 15 days.

Findings include:

The facility's Nutritional Assessment policy dated as revised December 2011 documents: Nutritional assessments will be completed upon admission and with changes in condition that put the resident at risk for impaired nutrition. Nutritional assessments will be conducted by the interdisciplinary team and the dietitian will include an estimate of the resident's calorie, protein, nutrient, and fluid needs.

The facility's Weight Assessment and Intervention policy dated as revised June 2012 documents: Nursing staff are responsible for obtaining resident weights. An unplanned weight loss of 5% in one month, 7.5 % in 3 months, and 10 % in 6 months is considered significant, and greater than 5% in 1 month, 7.5 % in 3 months, and 10 % in 6 months is considered severe. The dietitian will be notified of weight changes in writing, and the dietitian should respond within 24 hours of receiving the notification. Interventions for undesirable weight loss include consideration of the use of supplements and nutrition/hydration needs.

1.) R13's Minimum Data Set (MDS) dated 6/21/22 documents R13 has severe cognitive impairment, R13 is not on a prescribed weight loss regimen, and R13 has had a weight loss of 5% or more in one month or 10% or more in six months. R13's Care Plan dated 6/21/22 documents R13 has a potential nutritional problem secondary to wound healing and includes interventions to prescribe diet as ordered and Registered Dietitian to

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S9999	Continued From page 16 evaluate and make dietary changes as needed. This care plan has not been updated to include R13's significant weight loss. R13's undated weight log documents R13's weights and identified significant weight loss as follows: 118.6 lbs. (pounds) on 4/27/22, 118.7 lbs. on 5/3/22, 109.7 lbs. on 5/9/22 (7.58 % loss), 103.6 lbs. on 5/12/22 (5.56% loss in 4 days), 103 lbs. on 5/24/22 (6.11 % loss from 5/9/22), and 101 lbs. on 8/22/22 (a 10% loss since 4/27/22.) R13's Physician's Order Summary Report dated 8/31/22 documents R13's diet is regular with ice cream once daily, and a frozen nutritional supplement once daily, and orders dated 7/22/22 to give ice cream daily in the afternoon and a frozen nutritional supplement in the evening for low BMI (Body Mass Index) and weight loss. R13's August 2022 Medication Administration Record (MAR) documents R13's ice cream is scheduled to be given at 12:00 PM. R13's Nutrition Note dated 4/28/22 at 12:48 PM recorded by V47 Registered Dietitian (RD) documents R13 was reviewed for recent admission, R13's BMI (Body Mass Index) was 21.6 and was adjusted for above knee amputation. This note documents, "Will monitor for need to modify nutrition." R13's Nutrition Note dated 5/26/2022 at 9:50 recorded by V47 documents R13 was evaluated for wounds and weight loss noted. R13's weight is down 15 lbs. since R13 admitted in late April 2022. R13 has a low BMI of 18.8, adjusted for left above knee amputation. V47 requested to change multivitamin to multivitamin with minerals, offer double protein at breakfast, a frozen nutritional supplement once daily, whole milk at meals, and change diet from Low Concentrated Sweets to regular. R13's Dietary Note dated 7/21/2022 at	S9999		

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S9999	Continued From page 17 12:04 recorded by V47 documents V47 requested to add ice cream with lunch. There is no documentation that R13's significant weight loss first noted on 5/9/22 was identified and reported to V47 until 5/26/22, and that nutritional interventions were implemented after 4/28/22 and prior to 5/26/22. There is no documentation that the frozen nutritional supplement was implemented prior to R13's hospital discharge on 6/1/22. On 8/29/22 at 10:18 AM V38 (R13's Family) stated R13 has lost weight recently but was unsure how much weight R13 has lost. On 8/31/22 at 12:23 PM V38 stated V38 was not sure what the facility was doing to help with R13's weight loss. On 8/29/22 at 12:39 PM R13 at all of the noodles with tomato sauce, mixed vegetables, and garlic bread. R13's meal tray did not contain whole milk or ice cream. On 8/31/22 at 12:17 PM R13's meal tray was delivered and contained ice cream but did not include whole milk. R13's meal ticket documented ice cream. On 8/31/22 at 12:22 PM V38 entered R13's room and requested V40 Certified Nursing Assistant get R13 a carton of milk. V40 returned with a carton of 2 % milk. On 8/31/22 at 12:25 PM V40 was passing drinks to residents. V40 stated: V40 knows what drinks to serve each resident based on knowing the residents. V40 usually works night shift, and V40 asks other staff as well. On 9/06/22 at 10:43 AM V3 Infection Preventionist confirmed R13's frozen nutritional supplement was not added to R13's orders/MAR until 7/21/22. On 9/06/22 at 3:26 PM V3 stated V47 assessed R13 on 4/28/22 and not again until	S9999		

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5/26/22, and there were no nutritional interventions implemented prior to 5/26/22.

On 9/06/22 at 12:31 PM V47 RD stated: Often times residents will drink better than they eat, so V47 recommends juice and milk with meals. The facility notifies me of weight loss when V47 is in the facility, or by telephone and electronic mail. V47 expects V47's recommendations to be implemented within 1-2 days, and V47 provides the recommendations to the facility on the same day V47 completes the evaluations. V47 assessed R13 on 5/26/22 for R13's significant weight loss. V47 cannot recall when V47 was notified of R13's significant weight loss. V47 would have given V47's recommendations sooner (than 5/26/22) if V47 was notified. V47 was in the facility on 5/5, 5/12, 5/23, and 5/26/22. V47 recommended Ice cream, whole milk, and the frozen nutritional supplement to promote weight gain.

2.) R70's MDS dated 7/14/22 documents R70 has severe cognitive impairment, is not on a prescribed weight loss regimen, and has a weight loss of 5% or more in the last month or 10 % or more in the last six months. R70's Care Plan revised on 7/17/22 does not address nutrition/weight loss or interventions.

R70's undated weight log documents R70's weights as follows: 121.3 lbs. on 4/11/22, 110.4 lbs. on 6/14/22 (8.99 % loss since 4/11/22), 103.2 lbs. on 7/31/22 (6.52 % loss since 6/14/22), and 107 lbs. on 8/31/22.

R70's Nutrition Note dated 4/21/2022 at 1:19 PM by V47 RD documents R70 was reviewed for weight loss, R70 has history of fluid issues and receives a diuretic. This note documents a

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recommendation to add whole milk and juice with all meals. R70's Nutrition Note dated 8/11/2022 at 1:56 PM by V47 documents: R70 was reviewed for weight loss at 1, 3, and 6 months and R70 has a healing stage III wound. V47 recommended a frozen nutritional supplement once daily to provide an additional 290 kilocalories and 9 grams of protein.

R70's Physician Order Summary Report dated 8/31/22 documents R70's diet order includes whole milk and juice at meals, and a frozen nutritional supplement once daily. There is no identified time of when the frozen nutritional supplement is scheduled to be given or documentation that R70 receives the frozen nutritional supplement daily as ordered.

On 8/29/22 at 12:14 PM R70's lunch tray included noodles with tomato sauce, mixed vegetables, garlic bread, mandarin oranges, and coffee. R70's meal ticket documents whole milk and juice with meals and does not document a frozen nutritional supplement. On 8/29/22 at 12:25 PM R70's meal tray did not include milk or juice. On 8/31/22 at 12:41 PM R70 ate 50 % of carrots, 75 % of mashed potatoes, all of the pears, and bites of roast beef. R70's meal tray did not include milk, juice, or a frozen nutritional supplement for the noon meals on 8/29 and 8/31/22.

On 8/31/22 at 3:30 PM V39 Licensed Practical Nurse (LPN) stated: Frozen nutritional supplements and ice cream are delivered by dietary staff on the meal trays. The frozen nutritional supplement is documented on the MAR. R70 does not get a frozen nutritional supplement in the evening.

On 9/06/22 at 12:31 PM V47 stated V47

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S9999	Continued From page 20 recommended milk, juice, and a frozen nutritional supplement to promote weight gain for R70. 3.) R95's MDS dated 8/3/22 documents R95 has severe cognitive impairment, is not on a prescribed weight loss regimen, and has a weight loss of 5 % or more in 1 month or 10% or more in 6 months. R95's Care Plan dated as revised on 8/27/21 documents R95's diet is regular and R95 is at risk for altered nutrition "due to new admission to the facility." This care plan includes interventions that R95 will be reviewed by the RD as needed, and this care plan has not been updated to reflect R95's significant weight loss and nutritional interventions to address weight loss. R95's undated weight log documents R95's weights as follows: 136.7 lbs. on 5/31/22 and 6/8/22, and 129.8 lbs. on 7/7/22 and 8/2/22 (5.05 % loss). R95's Nutrition Notes dated 7/21/22, 3/7/22, 2/26/22, and 9/9/21 and recorded by V47 RD, do not document an estimate of R95's calorie, protein, nutrient, and fluid needs... There are no documented thorough/complete nutritional assessments in R95's medical record since 7/24/21. R95's Nutrition Note dated 7/21/2022 at 11:35 AM documents R95 was reviewed for weight loss for the past month, and R95's BMI remains low at 21.6 with a goal of 23. R95's diet includes a nutritional shake 120 cc (cubic centimeters) four times daily. V47 suggested adding a frozen nutritional supplement for additional kilocalories. There is no documentation that R95 was evaluated by V47 after 3/7/22 until 7/21/22. R95's Physician Order Summary Report dated 8/29/22 documents an order on hold dated	S9999		

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S9999	Continued From page 21 2/28/22 for a nutritional supplement 120 cc four times daily, and an order dated 8/5/22 for a nutritional shake three times a day. R95's August 2022 MAR documents R95's nutritional shake is scheduled three times daily at 9:00 AM, 12:00 PM, and 5:00 PM. This MAR does not document the amount of the shake that R95 consumes or that R95 received the nutritional supplement on 5 times and refers to R95's Nursing Notes. R95's August 2022 Nursing Notes do not document R95 received the nutritional supplement as ordered 5 scheduled times during the month. On 8/29/22 at 12:33 PM R95 was eating in R95's room. R95's meal contained noodles with tomato sauce, mixed vegetables, garlic bread, mandarin oranges, and an orange drink. R95's meal ticket listed a nutritional shake for the noon meal. R95's meal did not contain a nutritional shake. On 9/6/22 at 9:15 AM V3 Infection Preventionist stated the facility was out of the (nutritional supplement) for a while and we replaced it with (nutritional shake). The nutritional shake is served by dietary staff on the meal trays. On 9/06/22 at 10:43 AM V3 provided R95's nutritional assessment dated 7/21/21 and stated that was the last full RD nutritional assessment V3 could locate for R95. On 9/06/22 at 12:31 PM V47 stated: R95's BMI was low. On 7/21/22 V47 recommended a frozen nutritional supplement. The nutritional supplement and shake are to promote weight gain and improve BMI. The goal is to have a BMI of at least 23 for age 65 and older. There was a shortage of the nutritional supplement, and we had switched to using the nutritional shake. V47 was off work during the first two weeks of July, and there was another RD who should have	S9999		

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covered in V47's place.

4.) R63's Order Summary Report dated 9/8/22 documents diagnoses including Unspecified Dementia, Unspecified Severity Without Behavioral Disturbances, Dysphagia and Psychotic Disturbance. This Order Summary documents an order for a regular diet, mechanical soft texture, regular/thin consistency, ground meat, whole milk and juice at all meals, add frozen nutritional supplement daily with a start date of 3/30/22.

On 5/12/22 at 12:22 PM, V47 Dietician documented R63 was reviewed for weight loss at one and three months, BMI (Body Mass Index) 24.9, diet is regular/mechanical soft, and appetite has declined. Will request whole milk and juice at all meals and review as needed for need to further modify.

R63's Weights and Vitals Summary report dated 9/8/22 documents R63's weight on 3/1/22 was 159.8 pounds and on 9/4/22 R63's weight was 135.8 pounds which was a 15.02% (percent) weight loss in six months.

On 8/31/22 at 12:29 PM R63's meal tray only contained a 2% carton of milk. There was no whole milk on R63's tray as ordered.

On 9/6/22 at 12:31 PM, V47 confirmed R63's recommendation for whole milk was for weight loss. V47 stated often times residents drink better than they eat, so V47 recommends milk and juice at meals.

(B)

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300.610a)
300.1010h)
300.1210b)

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 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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

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S9999	Continued From page 24 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. These Regulations are not met as evidenced by: Based on observation, interview and record review the facility failed to provide residents with pain control and pain assessments. The facility also failed to provide timely treatment of pain for a resident post above knee amputation. This failure affects two of three residents (R3, R214) reviewed for pain in the sample of three from a total sample list of 99. These failures resulted in R3 experiencing unrelieved pain and the ability to receive physical therapy post above knee amputation. Findings include: 1. R3's progress notes dated 8/5/22 document that R3 returned to the facility after sustaining a right above knee amputation due to Osteomyelitis and Methicillin Resistant Staphylococcus Aureus of the right leg. On 8/15/22 R3's Brief Interview Mental Status is documented as moderately impaired. R3's physician orders dated 8/5/22 document an order for Oxycodone 5 milligrams by mouth every 6 hours as needed for severe pain for the above the knee amputation. The last comprehensive pain assessment was completed on 5/5/22. R3's care plan dated 8/7/22 documents to give	S9999		

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(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
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analgesics as ordered by the physician and monitor and document for side effects and effectiveness.

R3's medical record first documented dose of pain medication (Oxycodone 5 milligrams) was on 8/6/22 at 3:40 PM. From 8/6/22 to 8/29/22, 29 of a possible 72 doses of Oxycodone were given to R3 for pain.

On 8/14/22, R3's progress notes document R3's indicator of pain was vocal complaints of the right thigh generalized as sharp, stabbing and aching. On 8/14/22 Methocarbamol 750 Milligrams was ordered every six hours as needed for muscle aches and muscle spasms. From 8/14/22 to 8/29/22, 14 of a possible 52 doses of Methocarbamol was given for muscle aches and spasms.

R3's 8/25/22 progress notes document verbal complaints of pain.

On 8/29/22 10:00AM R3 was observed laying in bed while grimacing and yelling, "Help!" and holding his right stump. On 8/29/22 at 10:30AM, R3 continued to yell, "Help, I hurt!" V12 Certified Nursing Assistant stated, "He yells a lot."

On 8/29/22 at 3:45 PM, R3 was yelling at R5 Certified Nursing Assistant, "My leg hurts! My right leg!"

On 8/31/22 at 8:25 AM V10 Certified Nursing Assistant stated, "He had been yelling for months, "I have pain, I have pain. I need medication!"

On 8/29/22 at 4:05PM, V7 Licensed Practical Nurse stated, "I called V11 Medical Doctor at 3:55PM for something for (R3's) pain. (R3)

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complains of pain a lot. Even before his amputation he yelled out in pain, but then he had Osteomyelitis, so who knows. (R3) recently told me that even air hitting the stump made him hurt. He needs something for breakthrough pain."

On 8/29/22 at 4:15PM, V7 Licensed Practical Nurse stated that V11 Medical Doctor had called with an order for Tylenol 1000mg for breakthrough pain.

R3's August 29, 2022, medication administration record does not document any Tylenol given for breakthrough pain.

On 8/31/22 at 10:29 AM, V17 Physical Therapist stated, "(R3) was in such pain that I couldn't even touch him to work on him. I told the staff, but he just couldn't tolerate therapy."

Physical therapy discharge notes dated 8/16/22 documents, "Poor tolerance to stretching due to severe pain."

On 8/31/22 at 10:47 AM, V19 Nurse Practitioner stated that the last time she saw R3 was on 8/24/22 and the staff didn't tell her that R3 was having increased pain.

The facility pain policy dated 2/23/22 documents, "The purposes of this procedure are to help the staff identify pain in the resident and to develop intervention that are consistent with the resident goals and needs and that address the underlying causes of pain. 1. The pain management program is to provide comfort to the resident. 2. "Pain management" is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment

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goals. 3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain b. Effectively recognizing the presence of pain. c. Identifying the characteristics of pain. d. Addressing the underlying causes of the pain. e. Developing and implementing approaches to pain management. f. Identifying and using specific strategies for different levels and sources of pain g. Monitoring to the effectiveness of interventions and h. modifying approaches as necessary."

2. R214's Brief Interview for Mental Status dated 8/11/22 documents R214 is cognitively intact.

On 8/29/22 at 10:50 AM, R214 stated she is in a lot of pain, but her pain medications are effective most of the time. R214 stated one day she had to wait 3.5 hours to get her call light answered. R214 stated she was needing pain medication. R214 stated she called her daughter (V20) because she was in so much pain and no one was coming to her room. R214 stated she was in so much pain that she couldn't breathe. R214 stated the nurse finally came in and gave her some pain medication but that soon after the paramedics showed up to get her because V20 called 911 to get her help. R214 stated it turns out my call light wasn't working correctly so no one knew I needed pain medicine.
On 8/31/22 at 8:51 AM, V20 stated R214 called her the evening of 8/26/22. R214 stated, "She called me and told me she was in so much pain she couldn't stand it. She was crying and told me she had to wait too long to get a pain pill and that the pain pill wasn't touching her pain. I called the ambulance because no one at the facility would answer the phone and I was scared because she was in so much pain and told me she had a bump behind her knee. I was afraid she had a blood

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clot. I drove to the facility right after I called 911. When I got there, she was leaving by ambulance and was still in pain."

R214's nurse's note dated 8/26/2022 at 7:13 PM documents, "Medical team came in stating (R214) called 911 and complains of severe leg pain and wanted to go to hospital. She took Norco about 30 min (minutes) ago. Upon leaving the facility daughter came in and (R214) will go to (hospital)."

On 8/31/22 at 2:30 PM, V43 stated on 8/26/22 at 6:30 PM, I was working down the other side of the hall. A kitchen aide (unknown) told me R214 was having pain and that she was wanting pain medication. I gave her a Norco (Hydrocodone Acetaminophen 5-325 milligrams). Then I heard people coming in and it was the paramedics. I didn't know they were coming. They arrived thirty minutes after I gave her pain medication. V43 stated she was in severe pain, and I am not sure how long she waited. V43 stated when the paramedics came her pain wasn't relieved and she was still in a lot of pain, so she went to the hospital. V43 stated V43 didn't know her call light wasn't working that night.

On 8/30/22 at 9:52 AM, V50 Maintenance Assistant stated he fixed R214's call light on 8/26/22. V50 stated when he pushed her call light, he discovered her light above the door didn't light up. He had to replace the light bulb. V50 stated he doesn't remember the time but it was late in the day.

(B)

Statement of Licensure Violation 4 of 5:
300.610a)

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300.1210a)
300.1220b)3)

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)

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S9999	Continued From page 30 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, 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 Regulations are not met as evidenced by: Based on interview and record review the facility failed to comprehensively assess a resident's aggressive behaviors upon admission for one of one resident (R46) reviewed for behaviors in the sample list of 99. This failure has the potential to affect 65 residents (R36, R42, R164, R365, R47, R88, R109, R17, R79, R92, R37, R18, R69, R3, R71, R22, R366, R76, R9, R64, R49, R63, R30, R67, R60, R72, R40, R57, R105, R113, R50, R85, R54, R44, R86, R48, R38, R23, R96, R16, R104, R12, R2, R53, R20, R78, R70, R33, R59, R5, R34, R6, R82, R32, R81, R13, R103, R110, R56, R29, R91, R77, R95, R55, R165) residing on the second floor of the facility. Staff allowed R46 unsupervised access to residents who are unable to protect themselves from R46's behaviors.	S9999		

Illinois Department of Public Health

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Findings include:

The facility's Behavior Monitoring policy dated 10/2015 documents, "Problematic behaviors will be identified and managed appropriately." "The facility staff and Attending Physician will identify individuals with a history of impaired cognition (e.g., Dementia, Mental Retardation), problematic behavior, or mental illness (e.g., Bipolar Disorder or Schizophrenia)."

R46's Face Sheet dated 8/19/22 documents an admission date of 6/18/22. R46's Admission Minimum Data Set (MDS) dated 6/27/22 documents diagnoses including Progressive Neurological Conditions, Schizophrenia, Wernicke's Encephalopathy, Alcohol Abuse with Intoxication and Unspecified Mood Disorder. This MDS documents a BIMS (Brief Interview for Mental Status) score of 9/15 indicating moderately impaired cognition.

R46's MDS dated 6/27/22 documents R46 had behaviors that put others at significant risk for physical injury, significantly intruded on the privacy of others, significantly disrupted care or living environment and wandering significantly intrudes on the privacy or activities of others.

R46's Baseline Care Plan dated 6/20/22 documents the only behavioral concern was wandering.

R46's Social Services Behavior Conditions Review dated 8/26/22 (after R46 was discharged to the Psychiatric hospital) documents R46's new or worsening behavior as aggressive behaviors towards staff and other residents. This Review documents R46 had exhibited physically

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aggressive behaviors towards residents.

R46's Nurse's Progress Note dated 6/20/22 at 1:54 PM documented by V22 Licensed Practical Nurse (LPN) documents, "(R46) having behaviors noted on this shift/ refusing medication. and (cussing) at nursing staff. NP (Nurse Practitioner) notified. Will continue to monitor."

On 6/20/22 at 8:37 PM, V22 documents, "(R46) noted having behaviors on this shift. (R46) was cursing/ yelling while (R46) was in (R46's) room. When staff tried to redirect (R46) continued to curse and yell. (R46) is now calm in bed call light within reach. Will continue to monitor."

R46's Nurse's Progress Note dated 6/24/22 at 11:17 AM by V44 Licensed Practical Nurse (LPN) documents, "(R46) has been trying to go to other (resident's) room with redirection. After being informed to not go into other (people's) (rooms) (R46) continued to do so. (R46) unplugged (R12's) air mattress and spilled water all over the floor. (R46) refused to come out by staff. (R46) was finally able to be redirected to (R46's) room. (R46) is now in (R46's) room in bed. Facility management notified.

R12's Diagnosis Report dated 9/8/22 documents diagnoses including Quadriplegia and Tracheostomy status.

On 7/8/22 at 4:25 PM, V4 LPN documents, "(R46) Behavior: "E) Hallucinations/Delusions/Psychosis" "1) Able to redirect and refocus" "3) Medication given" "2) Keep redirecting" "every shift."

On 7/14/22 at 9:33 PM, V44 documents, "(R46) having behaviors this evening. (R46) was being

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S9999	Continued From page 33 physically and verbally abusive to staff. (R46) stated "I will punch you and give you two black eyes" to the writer. (R46) was redirected and was unsuccessful. (R46) started to become a threat to staff, (residents), and self. (R46) started to push and shove furniture. MD (Medical Doctor) notified. (R46) is to be sent to (hospital) for altered mental status evaluation. When paramedics arrived (R46) became aggressive with EMT (Emergency Medical Technicians) by telling them "Bet nobody touches me" and screaming. Notified (POA) and facility (Administrator). Will continue to monitor." On 8/11/22 at 7:03 PM, V4 documents, "(R46) Behavior:" "B) Combative/hitting/kicking staff/resists care C) Crying/restlessness/agitated" "E) Hallucinations/Delusions/Psychosis" "1) Able to redirect and refocus" "3) Medication given" "2) Keep redirecting" "every shift." On 8/19/22 at 1:53 PM, V14 LPN documents, "(R46) became agitated with 2 other female residents (R52, R64). (R46) was in wheelchair on (R46's) way back from dining room. Female patients ambulating back from lunch in the 2 south dining room. Writer heard (R46) yell F*** you to (R52, R64). Writer began going toward the commotion. (R52, R64) yelled back F*** you. (R46) sped up his wheelchair and hit (R52, R64) directly knocking them to ground. Writer interviewed and separated all parties. (R46) stated they deserved it and they shouldn't talk to (R46) like that. PCP (Primary Care Provider) notified states to continue monitoring. emergency contact notified. (Administrator) and nurse managers notified. (R46) on 1-1 supervision at this time from time of incident." On 8/26/22 at 1:04 AM, V4 documents, "(R46) Behavior:" "C) Crying/restlessness/agitated" "1)	S9999		

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Able to redirect and refocus" "2) Keep redirecting."

On 8/26/22 at 2:58 PM, V14 documents, "(R46) left with transport for (Psychiatric) hospital in (the north) at (2:40 PM). Med list (medication list) and face sheet sent with. Writer reached out to (hospital) to give report, they stated they do not need a report just send (R46)."

R74's Order Summary Report dated 8/30/22 documents diagnoses including Cognitive Communication Deficit and Difficulty Walking. R74's Minimum Data Set (MDS) dated 7/21/22 documents diagnoses including Fractures and Other Multiple Trauma and History of TIAs (Transient Ischemic Attacks). R74's BIMS Evaluation dated 7/3/22 documents a score of 7/15 indicating moderately impaired cognition.

The facility's Preliminary Incident Investigation Report dated 8/25/22 at 6:22 PM, documents "Employee reported suspicion of unusual event on 8/25/22 approximately 6:22 PM. (R74) was in (R74's) room with door blocked open by a wheelchair belonging to (R46). (R74's) wheelchair was between R74 and the other wheelchair. (R74) was lying on the floor and reported that (R74) had fallen. (R74) was undressed from waist down and soiled depend lying on (R74's) bed. No injury noted by nurse assessing the resident. Both residents (R46 and R74) were sent out for evaluation. Physicians and POA/emergency contacts notified. Police notified. (V15 Police Officer) arrived at facility to interview staff and residents."

R74's Nurse's Note dated 8/25/22 at 5:00 PM, documents "CNA (Certified Nursing Assistant) notified nurse that (R74) was on the ground,

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undressed from the waist down and (R46) was wrapped in (R74's) bed sheet. CNA told second nurse. Nurse notified administrator; statement given. Doctor contacted gave order to send out for assessment. POA notified. (R74) assessed. (R74) Vital Signs WNL (Within Normal Limits). No c/o (complaints of) pain. Sent (R74) to hospital to be assessed.

On 8/29/22 at 3:55 PM, V5 Certified Nursing Assistant (CNA) stated on 8/25/22 around dinner time, 5:00 PM-6:30 PM, V5 noticed R46 standing at the nurse's station with no wheelchair with R46. V5 stated that V5 went to look for R46's wheelchair. V5 looked in a couple of rooms but then came to R74's room and the door would only open a small way.V5 stated that there were wheelchairs blocking the door and R74 was on the floor on the other side of the wheelchairs. V5 stated R74 had no clothes on from the waist down and R74's used incontinent brief was laying on the bed away from R74. V5 stated V5 could not fit through the opening without pushing the wheelchairs into R74 so V5 got the nurse (V6 Licensed Practical Nurse/LPN) and V6 was able to fit through the opening and climbed over the bed to get to the other side of the wheelchairs and rearranged things so V5 could come in and assist. V5 stated they got R74 up off the floor and dressed and during this time R46 returned to the room with R74's personal bed sheet wrapped around R46. V5 stated R46 was screaming at them to get out of R46's house. V5 stated after they got R74 up and R74's pants back on V5 left R74 with V6. V5 stated that R46 is a resident with "high behaviors." V5 also stated that R46 is a highly disturbed man that is abusive, mean and nasty.

On 9/8/22 at 10:30 AM, V25 confirmed that there

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was no behavior assessment completed for R46 upon admission. V25 stated that R46's behavior assessment was not completed until 8/26/22.

The facility's Resident Room Roster provided on 8/30/22 documents 65 residents (R36, R42, R164, R365, R47, R88, R109, R17, R79, R92, R37, R18, R69, R3, R71, R22, R366, R76, R9, R64, R49, R63, R30, R67, R60, R72, R40, R57, R105, R113, R50, R85, R54, R44, R86, R48, R38, R23, R96, R16, R104, R12, R2, R53, R20, R78, R70, R33, R59, R5, R34, R6, R82, R32, R81, R13, R103, R110, R56, R29, R91, R77, R95, R55, R165) reside on the second floor.

(C)

Statement of Licensure Violation 5 of 5:
300.2860b)7)
300.2940g)1)

Section 300.2860 Nursing Unit

b) General Requirements for Bedrooms

7) A nurses' call system shall be provided in accordance with Section 300.2940(g).

g) Nurses' Calling System

1) Each resident room shall be served by at least one calling station and each bed shall be provided with a call station. One call station may serve two adjacent beds. A nurse call shall register at the nurses' station and shall activate a visible signal in the corridor at the resident's door, and in the nurse's station. In multicorridor nursing units, additional visible signals shall be installed at corridor intersections. In rooms

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(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 37	S9999		

containing two or more calling stations, identifying lights shall be provided at the nurses' station.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure the emergency nurse call system had a functioning light for R214 and a properly functioning emergency nurse call device for R100. R214 and R100 are two of 24 residents reviewed for call lights on the sample list of 99. This failure resulted in R214 having excruciating pain for three hours and requiring R214 to be sent to the emergency room for evaluation.

Findings include:

1.) R214's Brief Interview for Mental Status dated 8/11/22 documents R214 is cognitively intact.

On 8/29/22 at 10:50 AM, R214 stated she is in a lot of pain, but her pain medications are effective most of the time. R214 stated one day she had to wait 3.5 hours to get her call light answered. R214 stated she was needing pain medication. R214 stated she called her daughter (V20) because she was in so much pain and no one was coming to her room. R214 stated she was in so much pain that she couldn't breathe. R214 stated the nurse finally came in and gave her some pain medication but that soon after the paramedics showed up to get her because V20 called 911 to get her help. R214 stated it turns out my call light wasn't working correctly so no one knew I needed pain medicine.

On 8/31/22 at 8:51 AM, V20 stated R214 called her the evening of 8/26/22. R214 stated, "she called me and told me she was in so much pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001457	A. BUILDING: ____ B. WING ____	09/14/2022

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S9999	Continued From page 38	S9999		

she couldn't stand it. She was crying and told me she had to wait too long to get a pain pill and that the pain pill wasn't touching her pain. I called the ambulance because no one at the facility would answer the phone and I was scared because she was in so much pain and told me she had a bump behind her knee. I was afraid she had a blood clot. I drove to the facility right after I called 911. When I got there, she was leaving by ambulance and was still in pain."

R214's nurse's note dated 8/26/2022 at 7:13 PM documents, "Medical team came in stating (R214) called 911, complains of severe leg pain and wanted to go to hospital. She took Norco about 30 min (minutes) ago. Upon leaving the facility daughter came in and (R214) will go to (hospital)."

On 8/31/22 at 2:30 PM, V43 stated on 8/26/22 at 6:30 PM, I was working down the other side of the hall. A kitchen aide (unknown) told me R214 was having pain and that she was wanting pain medication. I gave her a Norco (Hydrocodone Acetaminophen 5-325 milligrams). Then I heard people coming in and it was the paramedics. I didn't know they were coming. They arrived thirty minutes after I gave her pain medication. V43 stated she was in severe pain, and I am not sure how long she waited. V43 stated when the paramedics came her pain wasn't relieved and she was still in a lot of pain, so she went to the hospital. V43 stated V43 didn't know her call light wasn't working that night.

On 8/30/22 at 9:52 AM, V50 Maintenance Assistant stated he fixed R214's call light on 8/26/22. V50 stated when he pushed her call light, he discovered her light above the door didn't light up. He had to replace the light bulb. V50

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S9999	Continued From page 39 stated he doesn't remember the time, but it was late in the day. 2.) On 8/29/22 at 11:00 AM, R100 was lying in bed. R100's call light was attached to the mattress. V36 stated when she pushes it, it does not go off (activate the nurse call system). At that time, R100 attempted to activate call light device and it did not activate the call system. The call light device button, when pushed slowly, did not activate the nurse call system. The call light system did activate only when the button on the device was pushed fast and hard. (B)	S9999		