STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005227	A. BUILDING: _____ B. WING _____	03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
S 000	Initial Comments Annual Licensure and Complaint 2281559/IL143981	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 3): 300.610a 300.690c) 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 c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. These requirements were not met as evidenced by: Based on interview and record review the facility failed to implement their policy by failing to report the death of a resident after a fall, to the Illinois Department of Public Health (IDPH) for one(R2) of three residents reviewed for falls. Findings include: R2's Fall Report dated 01/05/2022 at 4:30 PM documents in part, Incident Description: Writer alerted by sound of resident's voice during rounding and observed resident lying on the floor. Per resident, "I fell and I can't get up." Immediate Action Taken: Body assessment completed and resident was noted with visible blood in peri area. Resident unable to move lower extremities. Injuries Report Post Incident: Swelling, right iliac crest (front) R2's Nursing Progress Note (draft) 1/6/2022 at 3:00 AM notes in part, Upon round resident was noted unresponsive, no up and down chest movement noted. Resident was pronounced expired at 3:00 am. On, 03/03/2022 at 1008, V2 (Director of Nursing)	S9999		

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S9999	Continued From page 2 said, R2's fall incident should have been reported to IDPH (Illinois Department of Public Health) Facility's undated policy "Incidents/Accidents/Falls" documents part, Policy: "The facility will ensure that incidents and accidents that occur involving residents are identified, reported, investigated and resolved." Procedure: 13. "Any incident/accident/fall that meets the reporting criteria of the state/federal regulations will be reported timely and accurately, to include the initial as well as the follow up report." (no violation) Statement of Licensure Violations (2 of 3): 300.610a) 300.1210a) 300.1210b) 300.1210d)2)3)5) 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	S9999		

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S9999	Continued From page 3 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 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: 2) All treatments and procedures shall be administered as ordered by the physician.	S9999		

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S9999	Continued From page 4 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 300.3240 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) Based on observation, interview and record review the facility failed to follow policy on treatment documentation per physician order of sacral pressure injury and failed to follow care plan for 1 (R1) out of 4 residents reviewed for pressure injury prevention. Facility failures includes lack of monitoring when R1's sacral pressure injury was first identified already as Stage 3. And for lack of performing treatments as ordered by physician that resulted to R1's sacral pressure injury worsening from Stage 3 to Stage 4.	S9999		

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S9999	Continued From page 5 Findings include: Facility's policy on Wound Cleansing and Dressings reads: It is the policy of this facility to cleanse all wounds to clear exudates, bacterial contamination, and debris from the wound bed. Optimal wound healing cannot proceed until inflammation producing substances are removed from the wound bed. Wound cleaning is completed as indicated in the physician's order by the licensed nurse. Under documentation: Documentation of the dressing change is completed on the Treatment Administration Record (TAR). Additional documentation may be completed in the nurse's notes. R1's care plan on wound was documented that resident (R1) intervention for sacral wound treatment was to provide treatment as order by Medical Doctor (MD). Per weekly wound evaluation: R1 has pressure injury on the sacrum that was facility acquired and was first identified on 1/28/2022 as Stage 3. As documented on 1/28/2022 R1's sacral pressure injury was staged as a 3. Measurement was as follows: Length 3.0 centimeters, Width 1.0 centimeter and Depth 0.0. On 2/5/2022 R1's sacral pressure injury was still stage as 3. Measurement was as follows: Length 1.2 centimeters, Width 1 centimeter and 0.4 centimeter. On 2/17/2022 R1's sacral pressure injury was increased to stage 4. Measurement was as follows: Length 2.5 centimeters, Width 1.6 centimeters and Depth 1.1 centimeters. Sacral pressure injury depth increased from 0 on 1/28/2022 to 0.4 centimeter on 2/5/2022 to 1.1 centimeters on 2/17/2022. There was an increased on R1's sacral pressure injury depth from 0.4 to 1.1 centimeters.	S9999		

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S9999	Continued From page 6 On 3/2/2022 at 11:26 AM. V7 (Wound Care Nurse / Licensed Practical Nurse) stated, that when she assessed R1's sacral pressure injury it increased from stage 3 to stage 4 because the bone and muscle are exposed. V7 said, "Yes, R1 has a pressure injury on her sacral, and it increase from stage 3 to stage 4 because during my assessment bone and muscle were exposed. I work weekdays only and during week end we did not have any treatment nurse before. Yes, there was no treatment nurse designated during weekend. But now the facility hired treatment nurse assigned for the weekend. But still nursing staff working on the floor must do the dressing when there is no treatment nurse. And dressing change or treatment should be signed by the nurse performing the treatment on the TAR (Treatment Administration Record). I know that if it is not documented, it means it is not done. And as I said, we don't have treatment nurse during weekend. In my notes I charted that R1's pressure injury on her sacral has an odor that is why I asked wound doctor for Daikins solution because it helps with the odor." On 3/2/2022 at 1:38 PM. R1 was seen in her room by writer with V7. R1 sacral pressure injury was seen with bone and muscle on the sacral area were visible that fits the definition of Stage 4 pressure injury. On 3/3/2022 at 10:08 AM. V2 (Director of Nursing) stated that in the event there is no wound care nurse on the floor it is the responsibility of the nurse that is working on the floor to do dressing change or treatment. And after each dressing change or treatment, TAR (Treatment Administration Record) must be signed or documented.	S9999		

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S9999	Continued From page 7 Per R1's Wound Assessment: Sacral Pressure Injury was identified on 1/28/2022 with physician order for foam dressing every Tuesday, Thursday and Saturday, order date 1/29/2022 and discontinued on 2/5/2022. No treatment was documented as done for the above order until 2/1/2022 or 5 days after R1's sacral pressure injury was identified. Then R1's sacral pressure injury was changed on 2/5/2022 to Calcium Alginate after cleansing with Dakins Solution per physician order and should be performed daily. Per Treatment Administration Record (TAR) of R1 it was not signed as done on the following dates: 2/13/2022 and 2/20/2022 that both falls on Sunday although it was ordered as daily. Per R1's Nurse's Notes dated 2/22/2022 was documented by V7 reads: Noted odor from sacral pressure injury. (B) Statement of Licensure Violations (3 of 3): 300.610a) 300.1210b) 300.1210d)3)6) 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	S9999		

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S9999	Continued From page 8 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 well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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	S9999		

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S9999	Continued From page 9 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) Based on interviews and record reviews, the facility failed to follow facility policy and failed to ensure that a resident was adequately monitored after a fall for one (R2) of three residents reviewed for falls. The facility failed to assess and monitor R2 after falling on 01/05/22 at 4:30 PM and was pronounced dead on 01/06/2022 at 3:00 AM after found unresponsive. Findings include: F2's electronic medical record (EMR) documents diagnoses including but not limited to: Malignant Neoplasm of Penis, Palliative Care, Acute Kidney Failure, Weakness, Abnormalities of Gait and Mobility, and Anxiety Disorder. R2's Fall Report dated 01/05/2022 at 4:30 PM documents in part, Incident Description: "Writer alerted by sound of resident's voice during rounding and observed resident lying on the floor. Per resident, "I fell and I can't get up." Immediate Action Taken: Body assessment completed and resident was noted with visible blood in peri area. Resident unable to move lower extremities. Injuries Report Post Incident: Swelling, right iliac crest (front)." R2's Nursing Progress Note (draft) 1/6/2022 at 3:00 AM notes in part, Upon round resident was noted unresponsive, no up and down chest movement noted. Resident was pronounced expired at 3:00 am.	S9999		

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S9999	Continued From page 10 On 03/02/2022 at 11:25 AM, V11 (Registered Nurse) said, "(R2) was transitioning. I tried to keep an eye on (R2). I found him unresponsive, (R2) expired. I don't know anything about a fall. (R2) didn't fall on my shift. The nurse (doesn't know who off-going nurse was) didn't say anything to me about a fall. If (R2) fell, I should have been informed during report. I don't know anything about any blood." V17's (Hospice Nurse) Hospice Progress Note (Handwritten "Routine Nursing Visit Assessment") of 1/6/22 at 12:30 AM, documents in part, "Pt (patient) had fall, whereas (R2) slid OOB (out of bed) per FN (Facility Nurse). Care was provided and (patient) returned to bed. (Facility Nurse) reports at start of shift (R2) was ok but when they came to reposition, during rounds (patient) had blood on pillow from either nose or mouth." V17's Progress Note (Typed, electronically signed on 1/6/22 at 2:42 AM) documents in part, call received from V11 states R2 had blood nose or mouth, wasn't sure. V11 notes at start of shift (R2) was fine, talkative, usual self, but when V11 completed rounding and was checking (R2), found dark blood on pillow and (R2) is slow to respond. Requested visit. On 3/2/2022 at 2:39 PM and on 3/9/2022 at 11:47 AM. V17 said, I was notified on 1/6/22 by facility that resident was having nose bleeding. V11 didn't tell me (R2) fell. I went out there to see (R2). Of course they (facility staff) cleaned (R2) up. There was no blood on (R2's) face, just a little blood on the pillow. I don't recall seeing any bruising (to the face), (R2) was unable to speak (transitioning, unable to get vital signs other than respiratory rate). I don't remember if I looked at R2's peri area.	S9999		

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S9999	Continued From page 11 (R2) wasn't sent to the hospital because I figured (R2) was at the end of life, (R2) had a DNR (Do Not Resuscitate), I believed (R2) was transitioning. We don't send them out (to hospital), it's understood (R2's) going to get to the point of transitioning, we make sure (R2's) comfortable. If the family had decided send (R2) out, we would have abided by that decision and sent (R2) out. I don't recall family requesting that (R2) be sent to the hospital. I would have called the physician if I had seen anything additional or the nurse had provided anything additional. This writer asked V17 if there was any policy or guidelines as to if or when a resident should be sent to the hospital, V11 said, "from experience I was seeing a patient who was transitioning. On 03/02/2022 at 3:08 PM, V14 (Licensed Practical Nurse) said, "I heard beating on the table, yelling that (R2) had fallen, me and two CNAs (Certified Nursing Assistants) went to (R2's) room, (R2) was on (R2's) knees. I assessed (R2), got mechanical lift, and (with the assistance of two CNAs) put (R2) back in bed. I called hospice. I spoke with both V16 (Hospice Nurse) and V17 (Hospice Nurse). I informed both that resident had fallen. I spoke with management team (V18, Former Infection Preventionist) and resident's family to let them know that (R2) had a fall. I put neuro checks in place. We document neuro checks on paper, they're not in the system (EMR). I completed a fall assessment. I was instructed by V18 to do a fall assessment, put neuro checks in place, notify family and hospice, and check frequently on resident. I did inform V11 that (R2) fell, (V11) would have had to continue the neuro checks. Requested R2's neuro check sheet on 03/02/2022 at 3:30 PM and 4:45 PM. Document was presented to this writer on 03/03/2022 by V1	S9999		

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S9999	Continued From page 12 (Administrator). Documentation was noted to be incomplete, that is to say, the last three neuro checks were not signed off by staff member that completed them. V1 stated V1 assumed V11 completed unsigned documentation. Writer asked V1 why V11 completed neuro checks on R2 when V11 had informed writer that V11 was not aware of R2's fall. V1 said, "maybe V11 forgot." Neuro check sheet (initiated 1/6/22 at 4:30 PM) documents "R2 was able to move all four extremities." Fall assessment (1/5/2022) documents, R2 did not have any falls within the last three months. Facility's undated policy "Incidents/Accidents/Falls" documents part, Procedure: 9. Neuro checks will be completed after any head trauma as well as after any unwitnessed fall (even if the resident states they did not hit their head) as per policy. 10. The occurrence is to be communicated shift to shift as part of the report until the resident is stabilize(d). (no violation)	S9999		