STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006233	A. BUILDING: _____ B. WING _____	C 03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING MO	833 SIXTEENTH AVENUE MOLINE, IL 61265

(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 Facility Reported Incident Investigation of 3-6-22/IL144649	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.3240a) 300.3240b) 300.3240d) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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 300.3240 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) d) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These requirements are not met as evidenced by: Based on interview and record review, the facility failed to keep a resident residing on a locked Dementia unit safe from physical abuse for one of three residents (R78) reviewed for abuse in the sample of 62. This resulted in V4/Certified Nursing Assistant being witnessed, by other staff members, physically abusing R78 by slapping R78 several times including slapping R78's face.	S9999		

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S9999	Continued From page 2 Findings include: Facility policy entitled, "Patient Protection Abuse, Neglect, Mistreatment and Misappropriation Prevention", dated 10/2021, documents, "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. (a) The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion". The facility's State Reportable Incident form (dated 3/10/22) documents the following incident occurred on 3/6/22: "(At) approximately 5:00 PM, (V6/Certified Nursing Assistant) and (V5/Activities Assistant) observed (R78) strike (V4/Certified Nursing Assistant) and then observed (V4) strike (R78). (At) Approximately 5:00 PM, (R78) was seated in her wheelchair blocking entry into the kitchen area in the dining room. (V4) was asked by (V5) to assist a resident who was rummaging in the kitchen area. (R78) was seated in the doorway of the kitchen. (V4) told (R78) she was going to move her out of the doorway. (V4) was pulling (R78) out of the doorway, (R78) reached behind with her right hand and slapped (V4) across her face and dislodged (V4's) glasses (breaking the nose piece). (V4) then reached around and slapped (R78) in the face from behind. (V4) attempted to pass by (R78) to get to kitchen to assist another resident in kitchen area when (R78) hit (V4) on the right arm. (V4) reached back and slapped (R78) on the left shoulder. (R78) again hit (V4) on the right arm and again (V4) reached back and slapped (R78) on the left shoulder. (V4) then left the unit immediately."	S9999		

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S9999	Continued From page 3 R78's Quarterly Minimum Data Set Assessment, dated 2/24/22, document R78's Brief Interview for Mental Status as 5 out of 15 which indicates R78 has little cognitive understanding. R78's EMR documents R78's diagnosis to include: Unspecified Dementia with Behavioral Disturbance. R78's Care Plan, dated 2/25/22 documents, "At risk for behavior symptoms r/t (related to) diagnosis of Dementia. (R78) can become physically aggressive toward staff when agitated by swinging her fist, kicking, threatening to hit staff. She becomes verbally aggressive by swearing, calling staff names, being argumentative, and raising her voice. Also makes accusations toward others that aren't true. Has taken other residents' wheelchairs to use for herself, refuses to be changed at times, refuses vitals sometimes" V4's employee file was reviewed for documentation of previous instances of resident abuse. V4, an employee of the facility, had no documented instances of resident abuse. On 3/16/22, at 9:10 a.m., R78 confirmed not being slapped by staff and stated, "If I was, I would hit them back." On 3/16/22, at 9:50 a.m., V2/Director of Nursing confirmed, through V2's investigation, that V4/Certified Nursing Assistant struck R78 on 3/6/22 which resulted in V4 being terminated and reported to the State Registry. V2 confirmed after R78's assessment, R78 was noted to have no injury. On 3/16/22, at 10:05 a.m., V5/Activities Assistant	S9999		

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S9999	Continued From page 4 confirmed the typed interview [dated 3/7/22 at 12 p.m.,] provided to V2 regarding V4 physically abusing R78. V5's typed statement documents, "Sunday March 6th at around 4:50pm. I asked [V4/CNA] to move [R78] out of the doorway. [V4] started pulling [R78's] wheelchair out of the doorway and [V4] was getting aggravated with [R78]. [R78] reached behind her and hit [V4] with an open hand in the face. [V4] slapped [R78] in the face from behind. [V4] continued to pull the wheelchair into the hallway and [R78] slapped [V4] in the body area as [V4] walked past her. [V4] hit her back. This happened three times-back and forth hitting." On 3/16/22, at 11:08 a.m., V6/Certified Nursing Assistant confirmed witnessing V4 strike the third time in the left side of R78's face. V6 confirmed no red marks were observed on R78's face after being slapped. On 3/18/22, at 2:04 p.m., V11/R78's Husband stated, regarding V78 being slapped, "If under normal circumstances, that would have never happened. She grew up in Rockford and could take care of herself." (B) 2 of 2 300.610a) 300.1010h) 300.1030b) 300.1035a)3) 300.1035a)4) 300.1210b) Section 300.610 Resident Care Policies	S9999		

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S9999	Continued From page 5 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 300.1030 Medical Emergencies b) The facility shall maintain in a suitable location the equipment to be used during these emergencies. This equipment shall include at a minimum the following: a portable oxygen kit, including a face mask and/or cannula; an airway; and bag-valve mask manual ventilating device. Section 300.1035 Life-Sustaining Treatments a) Every facility shall respect the residents'	S9999		

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S9999	Continued From page 6 right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 3) procedures for providing life-sustaining treatments available to residents at the facility; 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices; 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. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to provide CPR (Cardiopulmonary Resuscitation) upon identification of absence of breathing and pulse to one resident (R99) identified as having Full Code Advance Directives of three residents reviewed for discharge in the sample of 62.	S9999		

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S9999	Continued From page 7 This failure resulted in R99 not receiving Cardiopulmonary Resuscitation when found without a pulse and not breathing and placed 40 current residents (R1, R5, R6, R10, R17, R20, R26, R37, R38, R41, R42, R45, R47, R48, R50, R53, R57, R59, R64, R65, R72, R76, R79, R80, R81, R82, R83, R84, R88, R89, R93, R95, R149, R150, R200, R201, R202, R203, R204, R299) identified as having Advanced Directives indicating Full Code status at risk of not receiving life sustaining treatment. Findings include: Facility Policy/Cardiopulmonary Resuscitation (CPR): Adult dated 10/2019 documents: "Purpose: To attempt to restore cardiopulmonary circulation to a patient without a pulse or respirations. CPR is initiated unless one of the three following conditions is present: 1) a valid DNR (Do Not Resuscitate) order is in place. 2) initiating CPR could cause injury or peril to the rescuer; or 3) in the presence of obvious clinical death (e.g., rigor mortis, decapitation, transection, or decomposition). Suggested Documentation: Condition of patient, interventions provided, date/time CPR initiated, staff involved witnessing the event and patient response. Record time EMS (Emergency Management Services) physician, family, or resident representative called as well as time patient left center or expired and pronounced dead. CPR/Adult Cardiac Arrest Algorithm instructs to: Verify scene safety If victim is unresponsive, shout for nearby help. Activate emergency response system via mobile	S9999		

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S9999	Continued From page 8	S9999		

device (if appropriate).
Get AED (Automated External Defibrillator) and emergency equipment (or send someone to do so).
Look for no breathing or only gasping and check pulse (simultaneously) - if no breathing or only gasping and no pulse:
Initiate CPR and use AED as soon as possible - continue both until ALS (Advanced Life Support) providers take over or victim starts to move."

Physician's Order Report with orders as of 01/01/2022 indicates R99 was admitted to the facility on 09/19/2018, was 75 years old with diagnoses that include Alzheimer's Dementia, Hypertension, Dysphagia and Cardiac Arrhythmia.
Physician's order dated 8/2/17 indicate R99 was a "Full Code."

R99's POLST (Practitioner Order For Life-Sustaining Treatment) dated 8/2/17 indicates, "Attempt Resuscitation/CPR" if patient has no pulse and is not breathing.

Nurse progress Note dated 1/6/22 at 1:34pm indicates R99's vital signs were within normal limits; however, oxygen saturation level is documented as 89% on Room Air.

Nurse Progress Note dated 1/7/22 at 8:14am indicates (V8, LPN/Licensed Practical Nurse) went into R99's room and found R99 not breathing and cold to the touch at "6:38am on 1/7/2022; confirmed by (V7, RN/Registered Nurse/Unit Manager)." This note indicates family was notified at 7:00am, coroner was notified at 8:36am.
Note on 1/7/22 at 9:57am indicates, "Funeral home notified to pick up body and coroner also

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S9999	Continued From page 9 notified." R99's Medical record contained no documentation, and no documentation was presented for R99 between 1/6/22 at 1:34pm and 1/7/22 at 8:14am when documentation indicates R99 was found "not breathing and cold to the touch. On 3/18/22 at 8:00am V8, LPN (Licensed Practical Nurse) stated that she saw R99 at the beginning of the night (on 1/7/22)and at some point, during the night, " A new CNA (Certified Nurse Assistant) came and told me (R99) was breathing funny." V8 stated that R99 always had breathing problems - "was a mouth breather" - so V8 told the CNA to put the head of R99's bed up. V8 stated that she "later" went back and checked to be sure R99's head was up and R99 had "normal breathing for him." V8 stated that she did not do any assessment or vital signs because she didn't feel she needed to and there was nothing out of the ordinary. V8 stated that when they went to do the next rounds R99 "was gone." V8 stated that rounds are supposed to be done at 1:00am, 3:00am and 5:00am and that, "We found (R99) about 6:00am." V8 stated that she was then going to call the other nurse in the building, found out V7, RN (Registered Nurse)/Unit Manager was in the building, so she called V7 to come to R99's room. V8 stated that R99 was "cold and gray - not blue and (R99) had no pulse and was not breathing." V8 stated that she found out R99 was a full code after he was found with no pulse and not breathing and stated, "I didn't really know what to do." V8 stated that she notified the coroner, R99's family and later the funeral home. V8 stated that she did not recall notifying R99's Physician.	S9999		

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S9999	Continued From page 10 On 3/18/22 at 8:25am V7, RN/Unit Manager stated that she went in to assess R99 (on 1/7/22) and R99 was not breathing and cold to touch. V7 stated that she did not notify the Physician or call for paramedics because she thought R99 was "too far gone." V7 stated that she told V8, LPN to call R99's Physician, family, the coroner and funeral home. On 3/18/22 at 11:30am V7 stated, "When I first saw (R99) - I asked (V8) how long has he (R99) been this way?" and V8 didn't know. V7 stated, "I picked up (R99's) arm - it was kind of stiff and then set it back down on his chest. I agree with (V8), (R99) was grayish - not blue but his lips were somewhat bluish, and his mouth and eyes were open." V7 stated, "I don't usually chart, the nurse does - but I should have charted my assessment and notified the Physician." V7 stated there should have been documentation of R99's condition before, during and after being found unresponsive by both the nurse (V8) and the CNA. On 3/18/22 at 1:20pm V13, Medical Director stated, "If resident is a Full Code, staff need to initiate CPR. The nurse can't just assume death." V13 stated that staff should be notifying the Physician at the same time to get orders on how to proceed while continuing CPR until given direction to stop. V13 stated, "Always initiate CPR if the Advance Directives are Full Code." (B)	S9999		