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
	IL6001002	A. BUILDING: ______ B. WING ______	C 07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SUBURBAN NURSING & REHAB CENTE	311 EDGEWATER DRIVE BLOOMINGDALE, IL 60108

(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 Investigation: 2275339/IL148801	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1210b) 300.1210c) 300.1220b)3) 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. 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	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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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. 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 interviews and record reviews, the facility failed to ensure a resident was free from abuse/involuntary seclusion in his room. This failure resulted in R2 being involuntarily secluded in his room when an unidentified person tied a plastic bag from R2's door handle to the hallway	S9999		

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S9999	Continued From page 2	S9999		

hand rail, preventing R2 from being able to exit his room. The facility in response to allegations of abuse and mistreatment failed to have evidence that all alleged abuse allegations were investigated; failed to prevent further potential abuse during the investigation; and failed to take action to prevent further incidents regarding seclusion during the investigation

The findings include:

1. On July 12, 2022, at 8:55 AM, R2 was ambulating in his room. R2 could not be interviewed due to his cognitive status. R2 was walking back and forth from his bed to his doorway, opening and closing his room door with ease without staff assistance or the assistance of a mobility device.

On July 14, 2022, at 2:17 PM, R2 was ambulating from his room to the hallway without staff assistance or the assistance of a mobility device.

R2's EMR (Electronic Medical Record) showed R2 was admitted to the facility on February 16, 2022 with multiple diagnoses including: toxic encephalopathy, dementia, anxiety, depression, and falls. The EMR continued to show R2 has resided on a secured unit in the facility since June 13, 2022.

During a general tour of the facility on July 12, 2022, at 8:53 AM, the second floor of the facility was noted to have four separate units. Two of the units were unsecured units. Two additional units were secured units. To enter the first secured dementia unit where R2 resides, no code is required for entry, but to exit the secured unit, a

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S9999	Continued From page 3 security code is required. The second secured unit required a security code to enter and exit the unit. R2's MDS (Minimum Data Set) dated May 25, 2022, showed R2 had severe cognitive impairment. The MDS continued to show R2 did not require the assistance of a mobility device. R2's care plans entitled "Potential Abuse-Neglect," initiated on May 25, 2022, showed "[R2]'s comprehensive assessment ... is at risk due to being a vulnerable person. [R2] demonstrates: depression, impaired cognition/communication, inadequate coping skills and diagnosis of dementia. [R2] benefits from daily cueing and reminders from staff." R2's care plan showed multiple interventions initiated on May 25, 2022, including, "Observe [R2] for signs of fear and insecurity during delivery of care. Take steps to calm the resident and help him feel safe." R2's care plan, entitled, "Physical and Psychosocial Needs," initiated on May 25, 2022, showed "I display compromised mental status and I demonstrate movement behavior (wandering, pacing or roaming). I have trouble understanding the immediate environment. Symptoms include: pacing, roaming, or wandering in and out of rooms; demonstrating signs and symptoms of mood distress, for example, poor appetite, insomnia (often up at night, wandering and pacing, anxious)." R2's care plan showed multiple interventions initiated on May 25, 2022, including, "If I leave the building or go into a peer's room or become aggressive, redirect me by: use distraction or 'therapeutic fib' techniques with me ... Avoid saying 'no' or 'you don't belong here' or using negatives in general. Tell me what can be done."	S9999		

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S9999	Continued From page 4	S9999		

The facility's undated initial report to the State Agency transmitted on July 4, 2022, at 4:10 AM UTC (Universal Time Coordinated), showed, "It was reported [R2] received inappropriate care." The report continued to show "Immediate action taken: Investigation initiated, family and physician notified, physical assessment done with no concerns noted, social service aware and performing well being checks, resident's needs were met via plan of care, care plans updated, and final report within 5 days."

The facility's undated final report to the State Agency transmitted on July 12, 2022, at 12:09 AM UTC, showed "Conclusion: "It was reported [R2]'s door was obstructed. Staff immediately removed obstruction and opened door to find [R2] comfortably in the room. [R2] is unable to say what happened. No person could be determined as responsible. All staff and residents on the unit interviewed, with none noting seeing the obstruction or it happening. [R2] is safe and comfortable in the facility. Staff commended for immediately addressing and reporting. Assessments on [R2] noted without concern or awareness of brief situation. Potential obstruction removed from unit. Family and MD aware of findings. Well-being checks in place. This will serve as the final report."

On July 3, 2022, at 2:36 PM, V13 documented, R6 was very verbally aggressive, chasing another resident to the secured unit hall doors, toward the dining room trying to hit the resident with his leg. V13 continued to document R6 went to the first floor nurse manager on duty.

R6's MDS, dated May 24, 2022, showed R6 was cognitively intact. The MDS continued to show R6 was admitted to the facility on May 21, 2021.

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S9999	Continued From page 5	S9999		

On July 12, 2022, at 4:03 PM, V1 (Administrator) said, "From what I can conclude, during my investigation, someone wrapped a bag around [R2]'s door knob to shut the door. I cannot substantiate this incident as abuse because I did not see it. Some staff have had abuse training since last week, but the training is still going on."

On July 12, 2022, V1 provided a document entitled, "Employee Education Record," dated, "7/5/22 - on." Topic of educations, "Abuse Policy, what is abuse and reporting." The education record included 40 staff signatures. An undated list of facility staff, provided by the facility, listed 123 staff members employed by the facility.

On July 12, 2022, at 4:40 PM, V1 said, "[R2]'s door was locked for such a short amount of time, it didn't affect [R2], and there was no negative consequence, so we are unsubstantiating any abuse."

On July 12, 2022, at 7:56 PM, V11 (CNA/Certified Nursing Assistant) said, "On July 3, 2022, I started my rounds around 3:05 PM and saw [R2]'s door was tied shut with a plastic bag. I went and got [V13] (RN/Registered Nurse) right away and we cut the bag off [R2]'s door. Once the bag was cut we still could not get the door open because [R2] was hanging on the door and pulling on the door knob. It took about ten minutes to get the door open after it was discovered. I have not received any in-services or trainings after this incident"

On July 13, 2022, at 9:39 AM, R6 said, "[R2] used to wander the hall with his hands in his pants and touch other people's food trays. [R2] was moved to the [secured unit]. [R2] came out of the

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S9999	Continued From page 6	S9999		

[secured unit] on July 3, 2022. The staff were not supervising him. I cannot stand [R2]."

On July 13, 2022, at 11:55 AM, V9 (LPN/Licensed Practical Nurse) said, "I was the nurse caring for [R2] on July 3, 2022, and had last seen [R2] at about 1:00 PM on July 3, 2022."

On July 13, 2022, at 1:02 PM, V13 (RN) said, "The last time I saw [R2] was before 2:00 PM (on July 3, 2022), and I did not see his room door because I did not know which room was his. At 3:15 PM on July 3, 2022, I told [V11] (CNA) to go to the secured unit, and I went to another resident's room for about five minutes. When I came out of the other resident's room, [V11] was waiting for me at the nurse's station and asked if [R2]'s room was supposed to be tied shut. We rushed to [R2]'s room and I saw a plastic bag tied from the door handle of [R2]'s room to the handrail in the hallway. Because the bag was tied from the door handle to the handrail, the door could not be opened. I called through [R2]'s closed door, and he started pulling on the door handle, trying to open the door from inside his room. [V11] went and got scissors and cut the bag, but we still could not open the door. I called [V14] (Housekeeping Director/Manager on Duty) to let him know we could not get the door open so I was not there when [V11] opened the door."

On July 13, 2022, at 2:01 PM, V14 said, "I sat at the nurse's station for about ten to fifteen minutes on Jul 3, 2022, but I could not stay because I was too busy. That was at about 1:45 PM."

On July 15, 2022, at 12:38 PM, V29 (Psychiatrist) said, "I just heard about [R2]'s incident on July 3,

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S9999	Continued From page 7	S9999		

2022, yesterday (July 14, 2022). I would expect them to inform me about this incident. When [R2] was involuntarily secluded, he would be more anxious, and panicky, and agitated. Staff could have protected [R2] by making sure he could not exit the secured unit he resides on. [R2] should not have been contained to his room by having a bag tied to his door, which is intentional seclusion."

On July 14, 2022, V1 said, "I did not interview the other nurses (V9 and V32) that were working on the second floor the day of the incident."

On July 14, 2022 at 1:58 PM, V4 (Agency CNA) said, "If I was locked in a room I would be very upset."

On July 14, 2022, at 2:01 PM, V9 (LPN), said, "I would feel very bad if I got locked in a room."

On July 14, 2022, at 2:03 PM, V23 (Agency CNA) said, "I would be upset if I was locked in a room and could not get out."

On July 14, 2022, at 2:06 PM, V24 (Housekeeper) said, "I would be scared if I was locked in a room I could not get out of."

On July 14, 2022, at 2:12 PM, V26 (Activity Aide) said, "If I was locked in a room, I would feel bad."

On July 14, 2022, at 2:18 PM, V25 (Agency LPN) said, "I would feel terrible and upset if I was locked in a room."

On July 14, 2022, at 2:58 PM, V27 (Agency CNA) said, "I would be scared if I was locked in a room I could not get out of."

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S9999	Continued From page 8	S9999		

On July 14, 2022, at 3:03 PM, V28 (CNA) said, "If I was locked in a room, I would do everything I could to escape that room."

On July 18, 2022, at 1:28 PM, V2 said, "There was never an incident report done on [R2] regarding the incident on July 3, 2022. An incident report should have been done."

The facility's undated policy entitled, "Physical Restraints/Seclusion," showed "Policy: It is the policy of the facility to use physical restraint only as a last resort and only after every other alternative to a physical restraint (based on assessment) that seemed to have the potential for being used successfully, has been tried, and has failed. The use of a physical restraint and/or device is to enable and promote functioning at the highest practicable physical, mental or psychosocial well-being. It will be used only after the resident has been assessed and it has been determined by the IDT (Interdisciplinary Team) that the restraint to be used is the least restrictive. Note: The facility does not practice 'seclusion' of residents for any reason with the only exception being used for monitoring a resident for a limited period of time to reduce agitation until professional staff can formulate a successful plan of care."

The facility's undated policy entitled, "Abuse Prevention Program," showed "Policy: It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property. Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings. The following procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation

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S9999	Continued From page 9	S9999		

of suspected abuse or neglect or a resident by a third party. Abuse Reporting: Policy- this facility will not tolerate resident abuse or treatment by anyone, including staff members, other residents, consultants, volunteers, staff of other agencies, family members, legal guardians, friends or other individuals ... For the purposes of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain ... 5. Involuntary Seclusion: Separation of the resident from other residents or from his or her room or confinement to his or room (with or without roommates) against the resident's will, or the will of the resident's legal guardian or representative."
(B)

Statement of Licensure Violations (2 of 2):

300.610a)
300.1210d)3)6)

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.

Section 300.1210 General Requirements for Nursing and Personal Care

d) Pursuant to subsection (a), general nursing

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S9999	Continued From page 10	S9999		

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.

These requirements were not met as evidenced by:

The facility failed to notify the abuse coordinator of an injury of unknown origin, investigate the injury and report the injury to the State Agency for R1 who was noted with bruising to the neck on July 5, 2022. R1's injury was not reported or investigated until July 12, 2022, during the survey.

2. On July 12, 2022, at 9:00 AM, R1 was in his room, sitting on his bed eating breakfast. R1 was wearing a hospital gown that was not tied around his neck and was draped across his lap. R1 had two bruises, dark purple in color, on the left side of his neck.

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S9999	Continued From page 11	S9999		

On July 12, 2022, at 1:35 PM, V8 (Wound Nurse) measured R1's neck bruising and said, "He has two bruises, one on top of the other. The lower bruise measures two centimeters long by 0.5 centimeters wide. The top bruise measures 4.7 centimeters long by 0.8 centimeters wide. The bruises are deep red in color, kind of reddish purple in color. I have not assessed his bruises before."

R1's EMR showed R1 was admitted to the facility on March 29, 2021, with multiple diagnoses including: dementia, Alzheimer's disease, psychosis, neck fracture, and difficulty walking.

R1's MDS dated June 9, 2022, showed R1 was severely cognitively impaired, required supervision for eating, and required extensive assistance of facility staff for all other activities of daily living.

R1's care plan entitled, "Potential Abuse-Neglect," initiated on March 30, 2021, showed "[R1]'s comprehensive assessment reveals a history of factors that may increase my susceptibility to abuse/neglect related to diagnoses: dementia with behavioral disturbances and [alcohol] abuse ... During heightened periods of distress, [R1] may become agitated with verbal/physical aggression, [R1] has a history of verbal aggression/physical aggression towards other staff members and co-peers." R1's care plan showed multiple interventions initiated on March 30, 2021, including, "Speaking calmly and professionally in a soft tone of voice. Staff should avoid raising own voice, since this tends to make [R1] more upset. This may cause the situation to escalate." R1's care plan entitle, "Cognitive Impairment," initiated on March 30, 2021, showed "[R1] is alert, oriented times one

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S9999	Continued From page 12	S9999		

being noted to only identify self ... [R1] is a poor historian, his attention span is delayed with response to stimuli and follows one step/verbal commands. His overall memory is decreased per any recall of recent events and short term/long term memory loss." R1's care plan showed multiple interventions initiated on March 30, 2021, including, "Provide reassurance to help the resident feel safe and secure. Use a calming, soothing tone of voice. Repeat information politely and respectfully. Avoid phrases using words such as 'just' and 'already,' avoid 'I just told you that,' for example."

The facility did not have documentation to show V1 (Administrator/Abuse Coordinator) was notified of R1's injury of unknown origin/neck bruising prior to July 12, 2022. The facility did not have documentation to show an abuse investigation had been initiated for R1's neck bruising prior to July 12, 2022.

The facility's undated initial report to the State Agency transmitted on July 12, 2022, at 9:37 PM UTC (Universal Time Coordinated), showed: "[R1] noted with a skin discoloration on left neck area." The report continued to show, "Immediate action taken: head to toe assessment completed, no other injuries or pain noted, nurse practitioner in house and x-ray ordered; resident unable to provide details as to the cause of the discoloration; physician and family notified; resident placed on well-being checks and care plan to be updated accordingly; police notified, report number to follow."

On July 12, 2022, at 1:53 PM, V2 (DON/Director of Nursing) said, "There was no noted skin condition for [R1] on July 5, 2022. On July 6, 2022, when the CNA (Certified Nursing Assistant)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001002	A. BUILDING: ____ B. WING ____	C 07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SUBURBAN NURSING & REHAB CENTE	311 EDGEWATER DRIVE BLOOMINGDALE, IL 60108

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

went into [R1]'s room there was ecchymosis (bruising) on his neck. V8 (Wound Nurse) was supposed to follow up on this. I have not done an investigation into this as an injury of unknown origin. An investigation should be started within 24 hours. We do not know how [R1] obtained this bruising. V5 (RN/Registered Nurse) notified V10 (Nurse Manager), but V10 did not notify the abuse coordinator."

On July 12, 2022, at 2:15 PM, V10 (Nurse Manager) said, "[V5] (RN) mentioned [R1]'s bruising to me on July 6, 2022. I told her to notify the doctor. [R1] has behaviors of becoming aggressive and when you try to stop him, he starts swinging. I did not assess [R1] right away because I was busy. I do not know how [R1] got the bruise, and I did not report this to the abuse coordinator. An investigation should have been done."

On July 12, 2022, at 2:20 PM, V2 (DON) said, "The nurse or the nurse manager should have reported this to the Administrator. A bruise of unknown origin is something that should be investigated. My expectation is staff should be reporting this as potential abuse. My expectation of V10 (Nurse Manager) is to investigate bruises immediately and report it."

On July 12, 2022, at 2:49 PM, V1 (Administrator/Abuse Coordinator) said, "I was unaware of bruising on [R1]'s neck from July 6, 2022. I will start the investigation now."

On July 13, 2022, at 11:41 AM, V2 (DON) said, "I have looked more into it and found out the bruise was there the day before on July 5, 2022. [V3] (Agency LPN/Licensed Practical Nurse) saw it but did not report it because he thought it looked old."

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S9999	Continued From page 14 On July 18, 2022, at 10:43 AM, V3 said, "I worked on July 5, 2022 and saw discoloration on [R1]'s neck. I rubbed it and could not see a skin tear. I looked in the chart and didn't see any documentation about it. I told the next shift nurse, and they were supposed to report it." On July 6, 2022, at 4:24 PM, V5 (RN) documented, the CNA on duty reported a skin discoloration on the left side of R1's neck, purplish in color. V5 continued to document the CNA observed the discoloration while in the process of getting R1 up for breakfast. V5 noted no swelling, no tenderness was noted at the site, the nurse practitioner was notified, and V5 called and left a message with POA (Power of Attorney). On July 8, 2022, at 10:33 PM, V7 (RN) documented R1 continued with deep purple discoloration on the left side of his neck. The facility's undated policy entitled, "Abuse Prevention Program," showed "Policy:... IV. Identification: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observe, hear about or suspect to the Administrator or an immediate supervisor who will immediately report the allegation to the Administrator ... V. Investigation: All incidents will be documented, whether or not abuse occurred, was alleged or suspected ... This policy will define how the investigation of abuse allegations and mistreatment will be conducted and outline the process of reporting, investigating and arriving at a conclusion or disposition of the allegation. All personnel must promptly report any incident or suspected incident or resident abuse, mistreatment or neglect, including injuries of	S9999		

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S9999	Continued From page 15 unknown origin. (An injury should be classified as an 'injury of unknown origin' when the source of the injury was not observed or known by any person, and the initial risk management investigation could not determine the cause of the injury.) ... Additionally, the person(s) observing an incident of resident abuse or suspecting resident abuse must IMMEDIATELY report such incidents to the Charge Nurse, regardless of the time lapse since the incident occurred. The Charge Nurse will immediately report the incident to the Administrator or the individual in charge of the facility during the Administrator's absence ... The Charge Nurse must complete an incident report and obtain a written, signed and dated statement from the person reporting the incident." (C)	S9999		