STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009112	A. BUILDING: _____ B. WING _____	C 06/17/2022

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S 000	Initial Comments Facility Reported Incident of 5/08/22/IL147103	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.690b) 300.690c) 300.1210b) 300.1210d)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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. 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 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. 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	S9999		

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S9999	Continued From page 2 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to follow abuse policy as follows: Preventing a resident (R2) with cognitive impairment from entering another resident's room without her (R1's) consent and supervision. Resident (R1) has physical limitations and was unable to avoid physical contact. Failures involved 2 residents (R1 and R2) reviewed for abuse. These failures resulted to R1 experiencing fear	S9999		

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S9999	Continued From page 3 and was placed in a threatening environment. R1 called for help, no staff came to assist before R2 was bitten and pushed off the bed by R1. Findings include: Facility abuse policy not dated in part reads: Policy Statement: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Abuse it the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Willful means the individual mush have acted deliberately, not that he / she must have intended to inflict injury or harm. Physical abuse is the use of physical force that may result in bodily injury, physical pain, or impairment such as: pushing, slapping, hitting, shoving, shaking, striking with or without object. Mental abuse is an emotional or psychological abuse. The verbal or nonverbal infliction of anguish, pain, or distress that results in mental or emotional suffering. On 6/16/2022 at 9:51 AM V2 (Licensed Practical Nurse) stated that R2 was with a nursing assistant performing bedside care. V2 stated that R2 uses a wheelchair because he needs extensive assistance with transfers and ambulation. R2 can answer questions but often times is confused. V2 further stated that R2 only ambulates with a walker if accompanied by a therapist. V3 (Registered Nurse) stated that R1 does not ambulate on her own, R1 uses a wheelchair. R1 is alert and oriented times 3 and cognition is intact. On 6/16/2022 at 10:05 AM R1 was seen sitting in her wheelchair, R1 was alert and able to express her thoughts well. R1 was asked about the	S9999		

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S9999	Continued From page 4 incident that happened related to R2. R1 said, "It was breakfast around 7:30 AM, nobody came to see me or get me up that day. I always want to sit up when eating breakfast. I don't believe in breakfast in bed. Around quarter to eight, I used my bell (pointing to a metal bell on the edge of the bed) to call but nobody came. Around 8:15 AM, I was informed that someone will bring breakfast but never came. So, I settled back to bed and fell asleep. I can't stand, I can't walk so I just slept. When I woke up, I saw R2 at the foot of the bed. I told him (R2) to get out because this is my room. R2 told me that this was his room too. I am fully awake now and yelled at him because he moved closer to me. I called for help and used the bell, Bing! Bing! Bing! He (R2) leaned with his chest on my face so that I could not breathe. I was able to push him with his back facing me. I think I bit him (R2) twice. He (R2) said, Aw! Then he kind of sat up on the edge of the bed. So, I pushed him, and he fell on the floor. Meantime, I was still yelling but nobody came. It was V4 (Maintenance) who first saw us. Stuff on my tray was knocked off onto the floor. R2 was moving up and down the hall with his wheelchair mostly asking for food. Just yesterday, I saw him going inside two rooms of other residents. R2 is confused. I was really scared and afraid. If only somebody on the staff would have been there, these things would not have happened. R1 stated, " I bit him (R2) on the upper back". R1 was seen very tense and often upset during the interview. On 6/16/2022 at 10:27 AM. R2 was in the hallway fronting the Nurse's Station sitting in a wheelchair. V2 was requested to bring R2 to his room. R2 knows the place but cannot tell the name of V2 or the date as of today. R2 said, "I walk but need somebody to help me. I don't know R1 or anything about R1."	S9999		

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S9999	Continued From page 5 On 6/16/2022 at 10:45 AM. V1 (Administrator) stated that I believe that what R1 was saying was true, that R2 went inside R1's room. But I don't think R2 knows what he was doing. We don't document incidents on the progress notes, but I have an incident report." V1 then presented an incident report document dated 5/8/2022. V1 was asked about the timeliness of reporting incident to State Agency since it was reported on 5/9/2022. V1 said, "I did not know it until 5/9/2022." At 12:45 PM, V1 was informed that per V4's statement, R1 informed him (V4) that she hit and bit R2. V1 was asked if V4 should have informed him or his designee. V1 did not answer but said, "I know you have concern about timely reporting of abuse." R1's full care plan was presented by V1 after request. Care plan was then reviewed with V1. V1 was asked why abuse was not included on R1's care plan. Then V1 called V9 (Minimum Data Set/MDS Coordinator) that later presented R1's abuse care plan. V1 was then asked about the incident on 5/8/2022, when R2 went into R1's room without her consent and was unsupervised. V1 said, "I am not blaming R1 for the incident. I know it was wrong. And again, as I said, I believe R1 was telling the truth." On 6/16/2022 at 12:20 PM. V9 (Minimum Data Set Coordinator) said that R2 ambulates but with one-person extensive assistance. V9 said, "R2 can ambulate but needs a walker. Like 10 feet ambulation, R2 needs extensive assistance." V10 (Restorative Nurse) said, "I don't think R2 can ambulate by himself without falling. On 6/16/2022 at 12:36 PM. V4 (Maintenance Assistant) said, "When I was passing by the hallway, I heard someone shouting, help! When I went into R1's room I saw R2 on the floor. R1	S9999		

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S9999	Continued From page 6	S9999		

was screaming I hit him and bit him. I know it was Sunday. I reported it to V5 (Director of Nursing). I was not given abuse training. But I know abuse is when someone is trying to beat someone. Yes, it seems like it will fall within abuse because R1 told me she bit R2."

On 6/16/2022 at 1:04 PM. V5 (Director of Nursing) said, "It was V6 (Registered Nurse) who was on duty on that floor on 5/8/2022. That was Sunday that R2 fell because he was looking for food. V6 said R2 lost his balance. V6 did not witness it, so I don't know why she did not talk to R1 and know what really happened. I know if she (V6) just talked to R1, R1 would have told her about R2. As you can see R1 is very oriented and can tell you clearly her thoughts. V4 did not inform me until 5/9/2022 (Monday) about the incident between R1 and R2. Then R1 told me that R2 came inside her room. She (R1) was feeling suffocated when R2 fell on her face, so she bit him (R2). V4 also stated that R2 was on top of her (R1). R1 also told V3 (Registered Nurse) that he (R2) climbed up on to her (R1's) bed.

On 6/17/2022 at 8:47 AM. V6 (Registered Nurse) said, "I was working that Sunday when the incident happened between R1 and R2. I guess R2 wandered in her (R1's) room. All the stuff on the table was scattered on the floor. R1 was so upset. I called V5 (Director of Nursing) but I cannot remember giving to her a written statement or giving a statement on 5/9/2022 at 11:03 AM because I was not working in that facility at that time. I also do not remember R2 saying that he wants to go to the hospital. I cannot remember R1 telling me that R2 was on her bed, and I did not witness the whole incident. I don't remember if R2 was already on the floor or

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S9999	Continued From page 7	S9999		

slid onto the floor. But I know I did not witness it. Oh yes, now I remember. R1 was very upset and told me that R2 was trying to get into her bed. There were other staff that went inside R1's room before me. I cannot remember if V4 (Maintenance) came in before me." V6 was informed about V6's statement related to what R1 told V4. V4 said, "I think I remember now, R1 said R2 was trying to get into her (R1's) bed. If that happened to me, waking up with a man inside my room I would be petrified and scared, not being able to move away from that man.

On 6/17/2022 at 9:35 AM. V8 (Certified Nursing Assistant) said, "I was working on 5/8/2022 passing out trays. Then I was informed to help out R3 because that day she also had a fall. While helping R3, a nurse told me to also help R2. I cannot remember her name (the nurse), but R2 was already on the floor when I came in to R1's room. R1 was very scared. R1 was saying that she (R1) was frightened by him (R2). I know R2 can walk but is very unsteady. I think that was possible for R2 to walk after R1 pushed him out of the bed. That makes sense, if R1 pushed him out of the bed. Then it is but natural for R2 to be moving himself away from R1. If I put myself in R1's situation, I would have been very frightened and scared. I understand that for the residents, their room is their home. I did not see her after the incident. But any female will feel traumatized if male stranger goes inside their room without consent.

R1 is 96 years old, initially admitted on 3/27/2019 in the facility. R1's medical diagnosis includes bilateral osteoarthritis of knees and muscle weakness. R1's brief interview for mental status (BIMS) score dated 4/1/2022 was 15. That means R1 has full cognition or intact cognition.

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S9999	Continued From page 8 R1's functional status assessment dated 4/1/2022 documents the following: R1 needs one-person extensive assistance on bed mobility or how resident moves to and from lying position, turns from side to side, and positions body while in bed. R1 needs one-person extensive assistance on transfers or how resident moves between surfaces including to or from: bed, chair, wheelchair. R1 was not ambulatory and uses wheelchair for mobility devise. No incident report related to R1 was provided by facility. R2 is 86 years old, initially admitted on 4/22/2021 in the facility. R2's medical diagnosis includes anxiety disorder, major depressive disorder, psychosis and obsessive - compulsive personality disorder. R2's brief interview for mental status (BIMS) score dated 3/31/2022 was 8. That means R2 has moderate cognitive impairment. R2 needs one-person extensive assistance on bed mobility or how resident moves to and from lying position, turns from side to side, and positions body while in bed. R2 needs one-person extensive assistance on transfers or how resident moves between surfaces including to or from: bed, chair, wheelchair. R2 walks in his room or corridor two or fewer times on the period of review. Balance not steady, only stabilize with staff assistance. R2 uses wheelchair for mobility devise. R2's care plan dated 5/8/2022 documents that R2	S9999		

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S9999	Continued From page 9 was reported to have entered a female resident's room in the middle of the night and laid in bed. Female resident in the said room was still asleep. R2's incident report by V5 (Director of Nursing) documents that R2 was inside R1's room on the floor. R2 was asking for food and was also asking to be taken to the hospital. (A)	S9999		