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
	IL6015648	A. BUILDING: _____ B. WING _____	C 12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SNR LVG OF HAZEL CREST	3701 WEST 183RD STREET HAZEL CREST, IL 60429

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S 000	Initial Comments Complaint Investigation 2296765/IL150502 refer to: 330.720 b) and 330.790 a) c) 1) 4) 2207272/IL151106 refer to: 330.720 b) 2298937/IL153123 refer to: 330.720 b), 330.790 a) c) 1) 4), & 330.4240 c) d) f) Facility Reported Incident (FRI) Investigations FRI of 5.10.22/IL148037 refer to: 330.790 a) c) 1) 4) FRI of 5.22.22/IL148034 refer to: 330.790 a) c) 1) 4) FRI of 5.23.22/IL148041 refer to: 330.720 b), 330.780 a) b) c), & 330.790 a) c) 1) 4) FRI of 7.10.22/IL149493 refer to: 330.720 b), 330.790 a) c) 1) 4) and 330.4240 c) d) f)	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 330.720b) 330.790a) 330.790c)1)4) Section 330.720 Admission and Discharge Policies b) No resident determined by professional evaluation to be in need of nursing care shall be admitted to or kept in a sheltered care facility. Section 330.790 Infection Control	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 a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. c) Depending on the services provided by the facility, each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, as applicable (see Section 330.340): 1) Guideline for Hand Hygiene in Health-Care Settings 4) Guidelines for Infection Control in Health Care Personnel These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that one resident (R7) received appropriate treatment for cloudy, red tinged urine, with reddish black particles. This failure resulted in R7 having a change in condition, was sent to the hospital, and was admitted with diagnosis that includes Severe Sepsis and UTI (Urinary Tract Infection). 2) failed to follow standard infection control and prevention hand hygiene and use of gloves during wound care; 3) failed to ensure that the urine drainage bag was placed appropriately to avoid back flow of urine, infection potential, and urine collection bag were visibly exposed to peers and visitors without privacy bag afforded. This failure affected	S9999		

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S9999	Continued From page 2 R7 and R8 who has indwelling catheter, and R7's wound care. Findings include: R7's face sheet documented that R7 admission date was 9/30/22 with diagnosis that includes but not limited to Paranoid Schizophrenia, Schizoaffective Disorder, Bipolar Type Psychotic Disorder with Delusions due to known Physiological conditions, Hypotension, Anemia, retention of urine, Failure to thrive. On 11/07/22 at 10:00am, R7 was observed in the living area with urine catheter and the urine collection bag noted with red tinged, cloudy urine with sediment (particles). The collection bag was hanging on the wheelchair arm rest and exposed with no privacy bag and physically visible to peers and visitors. When V4 of this observation and asked about resident rights to privacy, V4 stated that "I (V4) am RCC (Resident care Coordinator) working in the house as a caregiver today, R7 is a high functioning resident so (R7) knows what (R7) is doing, I (V4) guess it should be covered." At 10:10am, V2 HWD (Health Wellness Director) was made aware and shown R7 urine collection bag. V2 stated that "I (V2) can see it's bloody (referring to the urine in the urine collection bag). V2 stated that we (referring to facility staff) should keep the bag (referring to the urine collection bag) lower for gravity and provide privacy with the privacy bag." V2 stated that the facility did not have any privacy bags, and will have to be ordered. The surveyor asked why the urine bag should be kept lower, V2 replied for infection reasons because the urine in the urine collection bag tubing can flow back into the resident bladder causing infection like UTI (Urinary Tract Infection).	S9999		

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S9999	Continued From page 3 R7 informed the surveyor that at times it itches and cannot wait for the catheter to be removed. The surveyor then asked R7 whether R7 is aware of why the urine catheter was inserted, R7 stated for urine retention and (R7) believed (R7) is fine now. V2 stated that the facility licensed staff do not do anything with the urine catheter or the drainage bag. That the contracted home health staff take care of the indwelling catheter and change the bags. V2 was not observed assessing R7, no vital signs (Temperature, Pulse, Respiration, Blood Pressure) were taken. On 11/07/22 at 10:52am, interview with V5 LPN (licensed Practical Nurse) regarding observation and the reddish color of the urine in the drainage bag for R7. V5 stated that "I (V5) am not aware of the observation and none of the staff complained to me." When the surveyor asked about the shift-to-shift report from the nurse on 11pm to 7am shift, V5 replied there was no nurse when I (V5) resumed work at 7am stating "she (V20) must have left before I (V5) got here (referring to the facility). On 11/07/22 at 2:13pm, V2 stated that the hospice nurse has being notified, they are scheduled to come to the facility on Tuesdays and Thursdays to care for R7. The nurse will be coming tomorrow (referring to 11/08/22) to change the catheter. Asked whether there is a licensed nurse on duty during the night shift to determine whether R7 got appropriate care needed with change in condition of the urine and V2 replied, that the facility nurse cannot do anything about the catheter. On 11/07/22 as at 4:00pm, review of R7's record did not show any assessment documentation of	S9999		

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S9999	Continued From page 4 R7's vital status or notification of physician as to follow up on care to be rendered. R7's plan of care documented that R7 needs catheter care assistance 3x (three times) daily timed 7:00am shift I (One), 3:00pm shift II (Two) and 11pm shift III (Three) daily. Staff to empty the bag (referring to urine collection bag) at the end of each shift. The facility staffing daily assignment dated 11/06/22 presented showed that there was no licensed staff scheduled for 11pm to 7am shift. When this was brought to both V1 (Executive Director) and V2. V1 stated that "I am not required by regulations to have a nurse (referring to licensed Nurse) on night shift and if it is required show it to me, none of our residents are taking medication at night-time. If they need a nurse (V2) is on call all the time." Asked if in R7's situation of bloody urine whether R7 needs to be evaluated by the nurse, V2 who was present at the time stated "Yes". On 11/09/22 at 1:40pm, interview with V5 and V16 (LPN) regarding R7 and what intervention has been done regarding the bloody urine. V5 checked R7's electronic record and stated R7 was sent to the hospital during night shift, both V5 and V16 (LPN) did not know what the admitting diagnosis was. V5 then called the hospital. V5 stated that "R7 was admitted with diagnosis of severe sepsis and UTI". On 11/10/22 at 2:10pm, R7's ambulance patient care report dated 11/09/2022 documented in part that the facility called Memory Care center for (patient) with confusion with a possible urinary tract infection. The staff stated the patient is being sent out because of confusion and possible urinary tract infection. Patient (R7) has been confused since yesterday (referring to 11/08/22).	S9999		

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S9999	Continued From page 5 The ambulance staff was informed that R7 has a normal mental status of A&O x2-3. R7 was found in the room with Temperature of 101.7degree Fahrenheit On 11/14/22 at 10:15am, interview with V20 LPN (Licensed Practical Nurse) who identified self as the nurse on duty when R7 was sent to the hospital stated that "I (V20) was the nurse that sent R7 to the hospital. I work the night shift. V20 stated that I'm (V20) just filling in this morning because one of the nurses called off. V20 stated that (R7) became confused, a little blood was in the (urine collection Bag) and the urine was cloudy; so, I sent (R7) out to the hospital and R7 was admitted with sepsis and UTI. On 11 14/22 at 2:09pm, V21 NP (Nurse Practitioner) stated that she was not aware of R7 having bloody urine. V21 stated the facility did not notify her (V21). V21 stated that "it is not normal for resident's urine to be bloody or cloudy, because that indicates that something is going on, requiring a urinalysis any nurse (referring to Licensed Nurse) should know that. The surveyor asked V21 whether a Doctor (Physician)/NP should be notified V21 replied "Yes". V21 stated that they (referring to the licensed staff) should have notified me (V21), we have list of providers to be notified in case of any emergency, I (V21) told them that I will be out of town and will be back 11/15/22. They (Facility) can reach any of the other doctors from the group. The protocol is, if there is any emergency to send the resident to ER (Emergency Room) for Falls/UTI /Cellulitis. They are supposed to notify me (V21) or the other NP (Nurse Practitioner) in the group after. On 11/16/22 at 3:30pm, R7's hospital report dated 11/09/22 showed documentation that R7's	S9999		

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S9999	Continued From page 6 hospital admission Diagnosis includes Severe Sepsis and UTI with no hematuria. R7 was brought into the ED (Emergency Department) with altered mental status, fever, and confusion. R7 was complaining of fatigue and feeling of tiredness. The CBC result showed that WBC (White Blood Cells) value 17.5 (H) high with reference range of 4.2-11.0 K/mcl, RBC 3.48 (L) low with reference range of 4.00 -5.20 mil/mcl, HGB(Hemoglobin) 10.1 (L) low, HCT (Hematocrit) 31.4 (L) low with reference range of 36.0 -46.5 % (Percent). R7's hospital admission diagnosis includes Severe Sepsis and UTI with no hematuria. On 11/7/22, 11/09/22 and 11/14/22 the facility could not provide any facility policy and procedure on wound care, indwelling urine catheter and urine collection care. The facility in-service titled "What is sepsis/ infection prevention" was conducted with facility staff by V2 (and dated 9/12/22. Under what is Sepsis question statement, Sepsis is a person's overwhelming or impaired whole body immune response to an insult an infection or an injury to the body, or something else that provokes such a response. It's a serious condition and leading cause of death in hospitals. It's also the main reason why people are readmitted to the hospital. Sepsis occurs unpredictably and can progress rapidly. In severe cases, one or more organ systems fail. In worse cases, blood pressure drops, the heart weakens, and the patient spirals toward septic shock. Once this happens, multiple organs, lungs, kidney, liver may quickly fail, and the patient can die. On 11/22/22 at 3:00pm, both V1 (Executive director) and V2 acknowledge that the nursing care provided to R7 does not meet Professional	S9999		

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S9999	Continued From page 7 Standards of nursing care. V1 stated that "we (referring to the facility) will have to do better. I (V1) know that we (referring to the facility) dropped the ball on that one. When the surveyor asked for the facility policies and procedures on wound care, indwelling urine catheter and urine collection bag care. V2 stated that the facility did not have any policy on these issues. That the home health agency might have one because they are the ones that take care of the resident. The surveyor then asked both V1 and V2 who is responsible for making sure that the resident's needs are met in these care areas. V1 stated that "we (referring to the facility) will have to do better. R8 was observed being taken into R8's room in a wheelchair with the urine collection bag and tubing hanging on the back of the wheelchair. On 11/09/22 at 12:15pm, R8 was lying in bed with urine drainage bag and tubing sitting on the floor beside the bed. On 11/14/22 at 10:20am and at 11:08am, R8 was lying in bed with urine drainage bag and tubing observed sitting on the floor. When this was shown to V10 (caregiver), V20 LPN (Licensed Practical Nurse) stated "you (referring to the surveyor) mean it should not be touching the floor?" R8's medical record did not show that R8's indwelling catheter was care planned. No catheter assistance added to plan of care. On 11/14/22 at 11:00am, R7 complained that since (R7) came back from the hospital on 11/11/22 the dressing on (R7)'s buttocks (referring to the coccyx area) had not been changed. R7 stated that it needs to be changed. When this complaint was brought to V20's attention, V20 stated that "I have not had time to	S9999		

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S9999	Continued From page 8 check R7's wound, it's normally done by the home health care nurse". At 11:04am, V20 noted donning gloves without any hand hygiene and proceeded to show the surveyor the site of the pressure ulcer. V20 removed the already saturated dressing from the wound and did not perform any hand hygiene then wore the same dirty gloves to clean the wound. V20 removed the dirty gloves and donned new gloves without any hand hygiene. At 11:06am this observation was brought to V20's attention and V20 was asked about the facility infection control and prevention regarding hand hygiene and use of gloves. V20 stated "but I changed my gloves." When the surveyor asked about hand hygiene again, V20 replied "I did not wash my hands". The policy on Infection control and Prevention presented on hand hygiene dated 2016 documented in part that the proper hand of healthcare-associated infections is one component of standard precautions. Clean hands are the single most important factor in preventing the spread. It stops the spread of infectious agents through direct and indirect contact. Listed specific times in which hand hygiene should be done includes but not limited to before and after having direct contact with an individual, before and after providing care such as changing a dressing, after contact with any blood, body fluid, and non-intact skin. PPE (Protective Personal Equipment) use is not a substitute for proper hygiene, staff are encouraged to remember to always perform hand hygiene before applying and removing PPE. Types of PPE listed includes but not limited to gloves. The facility Job Description for Resident Care Coordinator presented dated 11/2021 documented in part that this position ensures the	S9999		

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S9999	Continued From page 9 quality care of all the residents. The position is responsible for daily operations as it relates to quality of care and services. The RCC manages the care staff in scheduling, evaluation and supporting the frontline care staff while reporting to the HWD (Health and Wellness Director). The facility Job description for Licensed staff (LPN/LVN or RN) presented dated 11/2021 documented in part the Licensed Staff Nurse is one of the main support providers to the (Facility) through assessments and care planning, treatment management services to residents, implementation, and evaluation of resident plan of care. Essential duties listed includes but not limited to providing general nursing care, prioritizing tasks to ensure optimum services to residents are request and needs change. Reporting any significant incidents and / or changes in the resident needs to Health and Wellness Director/ Executive Director. The facility Job description for Health and Wellness Director presented dated 01/2022 documented in part under position summary that the health and well ness position required an understanding and commitment to the mission and core values of the (facility) by exhibiting professional and ethical work practices. The Health and Wellness Director assures the quality care of all residents in conjunction with the Executive Director, Resident care Coordinator and other department managers. Essential duties listed includes but not limited to monitoring documentations from home health, hospice, and ancillary care providers, to assure appropriate communication of services provided and to assure needs of the resident are being met. Monitoring documentation systems to	S9999		

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S9999	Continued From page 10 ensure that all regulatory time frame for review and evaluations and service plan are met and that resident needs are met. The facility Job Description for Resident Care Coordinator presented dated 11/2021 documented in part that this position ensures the quality care of all the residents. The position is responsible for daily operations as it relates to quality of care and services. The RCC manages the care staff in scheduling, evaluation and supporting the frontline care staff while reporting to the HWD (Health and Wellness Director). The facility presented Illinois resident Rights-Assisted Living/Shared Housing as the Resident Rights policy the facility follows. Listed Resident rights includes but not limited to the right to live in an environment that promotes and support each resident's dignity and privacy. (B) (Violation 2 of 2) 330.780a) 330.780b) 330.780c) 330.4240c) 330.4240d) 330.4240f) Section 330.780 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	S9999		

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S9999	Continued From page 11	S9999		

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 330.785, 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 330.4240 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. (Section 3-610 of the Act)

d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter of the department. (Section 3-610 of the Act)

f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a

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S9999	Continued From page 12 resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These requirements were not met as evidenced by: Based on interview and record review the facility 1) failed to document and/or submit accurate descriptive summary to IDPH (Illinois Department of Public health) for 8 of 8 residents (R1, R4, R5, R6, R9, R10, R11 and R13) reviewed for fall incidents and significant change in condition, and 2) failed to keep one resident (R6) free from physical abuse. This failure affected R6 who was physically attacked and choked by R4 known to have aggressive behavior towards others. This failure affected R1, R4, R5, R6, R9, R10, R11 and R13 and has the potential to affect all 51 residents residing at the facility. Findings include: R1's face sheet showed that R1 was admitted with diagnosis that includes Hypertension, mixed Dementia, osteoarthritis, and Constipation. R1 had a fall on 5/10/22 and was sent to the emergency room. R1's ER visit summary report includes Injury of the head, Laceration of forehead and contusion of left hand. Laceration repaired with Dermabond. R1's laboratory result dated 05/06/22 showed that R1 had UTI (Urinary Tract Infection) with no physician or nurse practitioner follow up documentation before the	S9999		

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S9999	Continued From page 13 fall. The facility incident reported that the fall incident occurred on 04/24/22. The transmission verification Report showed that it was reported to IDPH (Illinois Department of Public Health) on 01/03/2013, nine years before the fall incident. According to the facility incident report dated 05/21/22 presented, (R5) was noted wandering and yelling throughout the building, R5 was re-directed several times but attempts were unsuccessful. (R5) began moving objects in the facility and continued to refuse redirection from staff. R5 became aggressive and combative towards the staff. R5 was sent to the hospital for a psych evaluation. R5 returned to the facility on 05/25/22. R5's outburst was related to UTI. R5 incident report showed that the final report was sent to IDPH 20 days later on 6/15/22. When this was presented to V2 and was asked about final reporting to IDPH within the timeframe of 7 days. V2 stated that she (V2) made the correction during that time because she (V2) was not aware that the facility should send a final report to IDPH. V2 stated R5 was throwing furniture, moving furniture around, and staff was unable to calm R5 down. R5 was aggressive towards self and the staff. R5's incident report dated 5/21/2022 showed documentation that R5 was noted yelling, combative, moving objects around the facility and refusing redirection. R5 was sent to the hospital for a psych evaluation and was treated with antibiotics for a urinary tract infection (UTI). V2 presented a transmission paper that was dated 01/14/2013 stating that the incident was initially reported. Which was nine years ago. and the final report dated 6/15/22, forty-six days after the initial incident.	S9999		

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S9999	Continued From page 14 R4 record face sheet showed that R4's admission date was 05/25/22 with primary diagnosis that included but not limited to Dementia and Hypertension. R4's face sheet showed that R4's move-in date was 05/25/22 with primary diagnosis that includes but not limited to Dementia and Hypertension. According to facility reported incident, the caregiver reported that R4's hands were noted around another resident's neck not identifying the resident. Surveyor asked V2 (Resident health wellness Director) who was the resident that was being assaulted. V1 ED (Executive Director) identified the resident as R6. V1 stated she was not aware that R6 should be identified in the report sent to IDPH (Illinois Department of Public Health). V2 then added I also did not know that the final report should be sent to IDPH by the 7th day. R4's plan of care showed that on 07/10/22 R4 tried to choke another resident identified as R6. On 7/23/22 was aggressive towards another unnamed peer. On 7/24/22 tried to hit another unnamed resident. R6's face sheet documented that R6 moved into the facility on 03/26/2018 with diagnosis that includes but not limited to Delusional Disorders Dementia in other diseases classified elsewhere with behavioral Disturbances, Paranoid Schizophrenia, and Charcot's joint knee. On 11/7/22 at 12:00pm, during this investigation V2 identified both V23 as the caregiver and R24 LPN (Licensed Practical Nurse) as the nurse on duty at the time of incident. V1 (Executive Director) and V2 stated that V23 and V24 no	S9999		

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S9999	Continued From page 15	S9999		

longer work at the facility. Both V1 and V2 did not treat this incident as a reportable incident identifying R6 as the resident being physically attacked. V1 stated that "but R4 has Dementia" stating that R4 did not know what (R4) was doing. V1 attributed not recognizing choking as a form of abuse to R4 having a diagnosis of Dementia. V1 also stated that she (V1) did not know that it is necessary to identify (R6). V2 stated R6 did not get injured, when the surveyor asked about how this was determined. V2 stated that R6 did not complained about the attack.

R4's plan of care showed the following incidents of R4 being aggressive towards peers:
On 07/10/22 R4 tried to choke another resident identified as R6.
On 07/23/22 R4 tried to get aggressive with another resident. Staff able to redirect.
On 7/24/22 R4 with fist clenched tried to hit another unnamed resident.

R4's facility resident record did not show any documentation that R4 was re-assessed for eligibility to be able to continue to reside at the facility.

The facility policy on Abuse, Neglect, Exploitation Prevention presented with effective date12/2018 and revised date 10/2021 documented in part that the purpose of the policy is to maintain the rights of all residents that includes but not limited to being free from abuse and mistreatment. This policy will provide a mechanism for prompt identification, reporting and investigation of any allegation and /or reasonable suspicion of abuse. It will ensure that all reporting of abuse is handled in accordance with regulatory standards. Procedure listed includes but not limited to the community Executive Director is responsible for

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S9999	Continued From page 16 the oversight and implementation of abuse prohibition and prevention program. The policy defined physical abuse as intentionally inflicting or allowing injury on a vulnerable adult by act or failure to act. Physical abuse listed includes but not limited to choking. R9 had a fall on 7/10/22 and sustained a bleeding laceration to the right eye, R9 was sent to the hospital. R9's laceration was steri-stripped closed at the hospital. R9 had another fall, a un-witnessed fall on 07/15/22 with bleeding noted on top of the head. On 07/25/22 R9 had a unknown injury and sustained a left hip fracture. The Smart sheet showed that this injury was initially not reported. Final report documentation showed that it was reported to IDPH on 8/1/22 6 days after the incident. V1 (Executive Director) could not present any documentation that a thorough investigation was conducted. R9's plan of care reviewed after the incident was dated 09/19/22. On 11/22/22 at 3:15pm, regarding reporting of R9's left hip fracture, V2 stated that she assumed that the injury was from the fall of 07/15/22 and since that fall was reported, she believed there will be no need to report it again. V2 stated R9 was sent to the hospital on 7/15/22 and the hospital did not address the fracture. V2 stated this is not an unknown injury but was unable to present any documentation that the was overlooked or that the injury was from the fall of 07/15/22. V2 stated that most of the reporting was late because I (V2) did not know that a final report on all incidents/accidents must be submitted within 7 days. R10 an unknown injury of bruising and edema above the right eyebrow per an initial incident	S9999		

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S9999	Continued From page 17 report dated 9/26/22. R10's final incident report was submitted to IDPH on 10/6/22. No thorough investigation documentation was presented. According to the facility incident report dated 10/19/22 timed 12:51pm, R11 had change in condition refusing to ambulate or stand. The initial incident was reported to IDPH on 10/20/22 at 5:35pm which was over the 24 hours' time frame. R13 had significant change in condition according to R13's incident report dated 09/26/22 and timed 2:32pm, V2 then presented another unrelated incident report dated 09/28/22. Final reports for both were not submitted to IDPH until 10/06/22 which did meet the regulatory time frame of 7 days. The facility Job description for Health and Wellness Director presented dated 01/2022 documented in part under position summary that the health and well ness position required an understanding and commitment to the mission and core values of the (facility) by exhibiting professional and ethical work practices. The Health and Wellness Director assures the quality care of all residents in conjunction with the Executive Director, Resident care Coordinator and other department managers. Essential duties listed includes but not limited to monitoring documentations from home health, hospice, and ancillary care providers, to assure appropriate communication of services provided and to assure needs of the resident are being met. Monitoring documentation systems to ensure that all regulatory time frame for review and evaluations and service plan are met and that resident needs are met.	S9999		

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S9999	Continued From page 18 The facility Job description for Licensed staff (LPN/LVN or RN) presented dated 11/2021 documented in part the Licensed Staff Nurse is one of the main support providers to the (Facility) through assessments and care planning, treatment management services to residents, implementation, and evaluation of resident plan of care. Essential duties listed includes but not limited to providing general nursing care, prioritizing tasks to ensure optimum services to residents are request and needs change. Reporting any significant incidents and / or changes in the resident needs to Health and Wellness Director/ Executive Director. (B)	S9999		