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	IL6003305	A. BUILDING: _____ B. WING _____	C 04/13/2023

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S 000	Initial Comments Complaint Investigation: 2312945/IL158531	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.690b) 300.690c) 300.1010h) 300.1210b) 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 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 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 300.1010 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 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest

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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.

This REQUIREMENT is not met as evidenced by:

A. Based on observation, interview, and record review the facility failed to assess a resident with a change of condition, failed to notify the physician of a change of condition, and failed to implement interventions for a resident with a fractured ankle for 1 of 3 residents (R1) reviewed for care and services in the sample of 7. This failure resulted in R1 experiencing a delay in treatment for her fractured ankle for 3 days and pain.

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S9999	Continued From page 3 B. Based on observation, interview, and record review the facility failed to report an injury of unknown origin to the Illinois Department of Public Health for 1 of 3 residents (R1) reviewed for abuse in the sample of 7. The findings include: R1's face sheet showed she was admitted to the facility on 1/18/21 with diagnoses to include dementia, other disorders of brain in diseases classified elsewhere, reduced mobility, weakness anemia, amnesia, and osteoarthritis. R1's facility assessment dated 2/24/23 showed she is severely cognitively impaired and requires extensive assistance of two staff members for bed mobility, transfers, toileting, and dressing. The same assessment showed R1 has an inattention behavior (easily distractible/having difficulty keeping track of what was being said) and disorganized thinking continuously present without fluctuations. R1's care plan initiated 1/25/21 showed, "[R1] has impaired cognitive function related to dementia... Interventions: Ask [R1] simple yes or no questions in order to determine her needs. She can be anxious at times so reassure her that we want to help her.... Present just one thought, idea, question, or command to [R1] at a time. Use task segmentation to support short term memory deficits..." R1's Patient Report from the mobile x-ray company with date of service 4/6/23 showed, "Right ankle, 2 views.... Findings there is a nondisplaced acute fracture of the distal fibula... Impression: Acute distal fibular fracture..."	S9999		

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S9999	Continued From page 4 On 4/13/23 at 9:57 AM, R1 was in her room sitting in her wheelchair. R1 said, "My foot hurts, take off my sock. I'd like to go to bed." R1 had a very short attention span while answering questions and repeatedly asked the surveyor to feel how soft her shirt sleeves were. R1 could not maintain focus long enough to give any more than short answers before losing her train of thought and refocusing on the environment around her. On 4/13/23 at 10:03 AM, V3 (Certified Nursing Assistant/CNA Supervisor) and V4 (CNA) were assisting R1 to bed with the mechanical lift and providing incontinence care. R1 expressed pain with movement of her right ankle and requested blankets be removed from her right foot because she was experiencing pain. V3 said, "[R1] does have a bruised foot. It is broken. We don't know how it happened." The facility provided a document dated 4/7/23 which was signed by V2 (Director of Nursing/DON) that showed, "Bruising noted 4/6/23 (Thursday), x-ray revealed fracture. Bruising noted to have some yellowing. Due to the pathology of bruising I interviewed Monday staff. Summary of interviews: Spoke to nurse [V11] that worked the floor Monday. She did not notice any bruising and no reports were made of pain, she did get report of bruising and swelling from CNA on Tuesday (4/4/23) after lunch assessed resident and attempted to notify doctor on Tuesday (4/4/23). On 4/13/23 at 11:05 AM, V2 said, "We really have never been able to determine how it happened." On 4/13/23 at 11:15 AM, V1 (Administrator) said she did not report the fracture to IDPH or report	S9999		

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an injury of unknown origin to IDPH because the facility knew exactly how it happened. V1 said they knew how it happened because they asked R1 right away on Friday (4/6/23, 2 days after the injury was reported) and she said she must have bumped it. V1 said she did not have to do an investigation because she knew what happened because [R1] told her.

On 4/13/23 at 12:55 PM, V12 (CNA) said, "It was after lunch when I went to take [R1's] shoe off. She usually is always saying "help me, help me" but this time she screamed out in pain. I looked at her ankle and saw bruising and swelling... I reported it to the nurse. I have no idea what happened but I'm sure it did not happen on that day because the bruising was already so set it that day. It was purple."

On 4/13/23 at 2:21 PM, V14 (CNA) said, "The first time I noticed her ankle was swollen and bruised was on Wednesday (4/5/23). I reported it to V11 (Licensed Practical Nurse/LPN) and she told me it had already been reported the day before (4/4/23) and was being handled.

On 4/13/23 at 2:37 PM, V11 LPN said, "I think it was last Wednesday (4/5/23) when I found out about [R1's] swelling. I don't remember who reported it to me. Typically, we fax the doctor explaining what we found, measurements, symptoms, and find out what testing they want done. I faxed the doctor. I didn't get a response. I know the DON (V2) had to contact the doctor. I don't know when [V2] called her but I know an x-ray was ordered." V11 said she does not have the fax she sent to the physician, did not complete an incident report, and did not document an assessment on R1.

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S9999	Continued From page 6 On 4/13/23 at 3:00 PM, V2 said, "The ankle injury was discovered on Tuesday (4/4/23). We started an investigation as soon as the results on Friday that showed the ankle was fractured. We made all the calls to staff on 4/7/23 when we knew it was fractured... [R1] is not a good historian. We looked at it and could not come up with a cause. We considered it an injury of undetermined origin. It's still of unknown origin because we can't identify what happened. I didn't report it to IDPH. We contacted corporate, they came in on Friday (4/7/23) and we did some talking and investigating. It was determined it did not need to be reported but I don't why. [V11] said she got report of the ankle injury and faxed the doctor. The faxes generally go on the clipboard at the nurse's station. I never did find the copy of the fax. We would typically scan it into the resident's record, but we don't know what happened to that. I looked everywhere. There was an x-ray done Thursday (4/6/23) and when I came in on Friday morning the results had not been received yet, so I contacted the x-ray company for the results. We didn't get the results until Friday afternoon that the ankle was fractured. Generally, if a fax was sent to the doctor, we would follow up with a phone call if we don't hear back. I feel like a fax was an acceptable way to contact the physician in this case because all we knew was, she had a bruise. It was not until Friday when we knew the ankle was fractured. If she had a fall with an injury, we would have called the physician or if there was something emergent. She should have documented a progress note and an assessment. I can't tell you with any certainty when the physician or the family was notified because I have to go with what is documented. I would have probably faxed the physician and if I had not heard back in a couple hours I would have called because of the pain [R1] was having. The nurse	S9999		

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S9999	Continued From page 7 was educated on what more she could have done. On 4/5/23 it was reported to V11 again by another CNA but V11 told her it was already handled. On 4/6/23 when we still did not have an answer, we called it in. It is important to follow up with the physician because we need an answer to treat the resident. The incident report was not completed until 4/6/23. We did find problems with nursing care, there was education done. Once we found out it was fractured, we set her up with orthopedics. From 4/4/23 through 4/6/23 there were no changes made to R1's plan of care. No acute treatment done such as ice, elevating, or splinting. There was nothing new until we knew it was fractured. I looked at the documentation though and she was not having pain unless the ankle was manipulated. Taking a sock on and off if you have a fractured leg would hurt. During mechanical lift transfers her foot could get manipulated but not bent or anything. It (ankle) would move with the lift up, at times they have to guide the feet and legs, and then it would move with the lay down." R1's 4/6/23 (2 days after the injury was initially identified) nursing note entered at 11:00 AM showed, "Upon assessment by this nurse resident noted to have faded purple/yellow/green bruising to right ankle with moderate swelling to extremity, and treatment in place to monitor area until bruising resolved. Very tender to touch. Measuring 14 cm x 12 cm. When resident asked what happened she said she thinks she banged it on something, but she wasn't sure when or what. MD (physician) and POA (Power of Attorney) updated. New order to obtain 2 view x-ray of right foot and ankle. Resident extremity elevated in bed... Tylenol given with some relief unless touched..."	S9999		

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S9999	Continued From page 8 R1's 4/6/23 nursing note entered at 8:20 PM showed, "... Right ankle area remains swollen and bruised. No complaints of pain unless touched or moved..." R1's 4/9/23 nursing note entered at 5:42 AM showed, "Updated MD of residents increase of pain in regard to fracture to right fibula. Pain signs include tensing, loud crying out, and facial grimacing. Request was made for PRN (as needed) pain medication..." The facility's policy and procedure with review date of 7/20/22 showed, "Acute Condition Changes... 3. Direct care staff, including Nursing Assistants will be trained in recognizing subtle but significant changes in the resident (for example, a decrease in food intake, increased agitation, changes in skin color or condition) and how to communicate these changes to the Nurse. Nursing Assistants are encouraged to communicate subtle changes in the resident to the nurse promptly... 7. The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response. 8. The attending physician (or practitioner providing back up coverage) will respond in a timely manner to notification of problems or changes in condition and status. a. The staff will notify the Medical Director for additional guidance and consultation if they do not receive a timely or appropriate response... Cause Identification; 1. The nursing staff and physician will discuss possible causes of the condition change based on factors including resident history, current symptoms, medication regimen, and existing test results. If necessary, the physician will order diagnostic tests or evaluate the resident directly... Treatment/Management; 1. The physician will	S9999		

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help identify and authorize appropriate treatments... Notification; 1. The nurse will notify the resident's attending physician or on-call physician when there has been: ... b. A discovery of injuries of an unknown source... 2. ... the nurse will notify the resident's family or representative when: a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source; ... 5. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status..."

The facility's policy and procedure with review date of 7/20/22 showed, "Bruise Monitoring; ... To provide proper monitoring, treatment, and documentation of any resident with skin abnormalities... 1. Identification - Bruising will be identified by the nurse through review of weekly skin assessments and the weekly shower sheets. Additionally, any reports generated verbally by direct care staff will be forwarded to the skin nurse in writing. All information will be reviewed by the DON or designee as the means to identify residents experiencing bruising..."

The facility's policy and procedure dated 10/3/22 showed, "Abuse Prevention Program; ... Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but no more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours... The nursing staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of unknown origin as soon as it is discovered. The report is to be documented on a facility incident report and provided to the nursing

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S9999	Continued From page 10 supervisor, administrator, or designated individual. Following the discovery of any suspicious bruises, lacerations, or other abnormalities of an unknown origin, the nurse shall complete a full assessment of the resident for other bruises, laceration, or pain... Internal Investigation: ... 3. For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an "injury of unknown source." An injury should be classified as an "injury of unknown source" when both of the following conditions are met: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury... External Reporting; 1. Initial reporting of allegations..." "B"	S9999		