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S 000	Initial Comments Annual Certification and Licensure Survey 2391622/IL156865 - State Licensure Findings: 300.1810 and 300.3210	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.1810 l) 300.3210v) Section 300.1810 Resident Record Requirements l) All Cook County facilities with Colbert Class Members shall submit to the Colbert Lead Defendant Agency, or successor Colbert Lead Defendant Agency, on a monthly basis, an accurate census of all Medicaid-eligible residents, the previous month's voluntary and involuntary discharges conducted under Section 300.3300, including any voluntary and involuntary discharges scheduled to be conducted within 48 hours after the end of the reporting month. This monthly census must be submitted on the form prescribed by the Colbert Lead Defendant Agency using secure (encrypted) email, no later than the fifth business day of each month. This requirement is NOT MET as evidenced by: Based on interview and record review, the facility failed to submit a list of Medicaid eligible residents to Colbert Agency every month and list of Colbert Class Members discharged from the facility. This deficiency affects one (R88) of one	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident reviewed for Colbert requirements and has the potential to affect the Medicaid eligible residents residing in the facility in the months of September 2022 to February 2023. Findings include: According to facility list of residents under Colbert Decree Program, R88 was one of the residents. R88 was discharged from the facility on 03/30/23. On 04/12/23 at 11:57 AM, V23 (Social Services Director) was asked regarding submission to Colbert Agency a list of Colbert class members who were discharged from the facility. V23 replied, "I am not aware that discharged or expired residents should be reported and submitted to Colbert." V23 was also asked if facility is submitting an accurate census of Medicaid eligible residents to Colbert Lead Defendant Agency every month. V23 stated, "I was not able to find the January and February 2023 census that we have to submit every month. The list of Medicaid eligible residents that I typically submit, I cannot find it. I cannot find the email confirmation as well. I don't know, I just cannot find it. I don't have the 2022 September/October/November/December proofs that the list of Medicaid eligible residents was sent to Colbert." V24 (Social Services) was also asked on 04/12/23 at 1:27 PM regarding monthly submission of Medicaid eligible residents to Colbert. V24 verbalized, "We don't submit a list of Medicaid eligible residents to Colbert every month. When they come here, they asked us on the residents on their lists who will benefit from their program."	S9999		

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S9999	Continued From page 2 There were no documentation or proofs presented by facility related to 2022 September to December and 2023 January to February 2023 Medicaid eligible residents submitted to Colbert every month. Section 300.3210 General v) All Cook County facilities with Colbert Class Members shall provide educational materials and information to all newly admitted Colbert Class Members within one to three days of admission, informing them of their rights and services under the Colbert Consent Decree, as prescribed by the Colbert Lead Defendant Agency. All Cook County facilities shall provide verification that the educational materials and information were given to the Colbert Class Members, as requested by a Colbert Defendant Agency. This requirement is NOT MET as evidenced by: Based on interview and record review, the facility failed to provide educational materials and information to all newly admitted Colbert Class Members related to members' rights and services and failed to ensure proper documentation for the materials provided. This deficiency affects two (R14 and R74) of three residents reviewed for Colbert requirements. Findings include: According to facility list of residents under Colbert Decree Program, R14 and R74 are members. On 04/11/23 at 1:15 PM, R14 was asked	S9999		

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S9999	Continued From page 3 regarding Colbert program. R14 stated, "I do not know anything about Colbert. I don't know any materials about Colbert." R74 was also asked regarding Colbert, stated, "Somebody came the other day and talked about Colbert and only gave this card. No other documents given to me." There was no documentation noted on R14 and R74 progress notes and medical records related to provision of educational materials and information on Colbert members' rights and services. On 04/12/23 at 1:27 PM, V24 (Social Services) was interviewed regarding Colbert educational materials and information. V24 replied, "We don't provide any educational materials and information about Colbert on members. Nothing had been provided to R14 and R74." (B) Statement of Licensure Violations (2 of 2) 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)2) Section 300.610 Resident Care Policies	S9999		

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S9999	Continued From page 4 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 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999		

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S9999	Continued From page 5 that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. These requirements were Not Met as evidenced by: 1. Based on observation, interview, and record review, the facility failed to ensure that residents were free from falls by not implementing interventions according to the resident centered care plans and facility protocols for supervision. These failures applied to three of three (R47, R90, and R92) residents reviewed for accidents and supervision and resulted in R90 experiencing repeated falls; R92 requiring three staples to the back of the head as a result of a head injury from a fall; and R47 sustaining a right femoral neck fracture as a result of a fall. 2. Based on interview and record review, the facility failed to supervise a resident with known wandering behaviors and failed to prevent a resident from to wandering into another resident's room and relieving himself. This failure applied to	S9999		

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two (R15 and R22) of two residents reviewed for supervision.

Findings include:

1.A. R47 is an 88-year-old female who originally admitted to the facility on 10/12/22. R47 has multiple diagnoses including but not limited to the following: nondisplaced fracture of right fibula, cerebral infarction, hemiplegia, dementia, muscle wasting, abnormalities of gait and mobility, need for assistance with personal care, lack of coordination, and type II DM.

On 4/11/23 at 10:15AM, R47 was observed to be lying in bed with facial grimacing. R47 said she was having pain to her right hip and wanted to get out of bed. Attempted to interview R47 about fall incident on 4/1/23. R47 said she knows she recently hurt her hip from a fall, but she does not remember what had happened.

At 10:30AM, V19 (Licensed Practical Nurse/LPN) was interviewed regarding R47. V19 said she was not present when R47 fell, but she knows she fell in the dining room during dinner shift, and she broke her hip.

Facility progress note dated 4/1/23 at 6:41PM states in part but not limited to the following: R47 was observed on the floor in the dining room near the table, lying on R47 back with knees bent next to resident wheelchair and complaining of right-side hip pain. R47 said she was reaching for something for another resident and slipped and fell.

On 4/12/23 at 2:42PM, V29 (Restorative Licensed Practical Nurse) was interviewed regarding incident with R47. V29 said R47 fell in the dining

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room during dinner time on 4/1/23. She said she was reaching for something that had fallen on the floor. Says no staff were in the dining room at this time. V2 (DON) interjected and said actually V28 (Certified Nursing Assistant/CNA) was in the dining room charting at the time of the fall, but her view was obstructed.

On 4/13/23 at 10:29AM, V28 was interviewed regarding incident on 4/1/23 with R47. V28 said she was standing outside the dining room charting on a mobile laptop by the nursing station. V28 heard a loud bang and looked behind but did not see anything. A couple minutes later, I walked in the dining room to check what happened and I saw R47 on the floor screaming. She was on her bottom with her knees bent. I asked her what happened and R47 said she was reaching for something and fell. This happened around the end of dinner time. I was not assigned to supervise the dining room; I was charting near the nursing station. There was no other CNA present in the dining room at the time of the fall. At the end of the meal, the CNA assigned to the dining room will transport residents back to their rooms. There are times when a CNA may not be present in the dining room during this time.

Hospital Inpatient Discharge Summary dated 4/1/23-4/6/23 state in part but not limited to the following: Active Hospital Problems: Closed right hip fracture; Summary of admission and hospital course: 88-year-old female who presented to the emergency department with a mechanical fall. In the emergency department, she was found to have acute subcapital right femoral neck fracture with posterior angulation.

R47 care plan with start date of 10/20/22 started in part but not limited to the following: Problem:

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S9999	Continued From page 8 R47 is at risk for falls due to weakness, impaired balance, decreased cognition, on psychotropic medication, and incontinence. Goal: R47 will be free of falls Approaches: Increased staff supervision with intensity based on resident need. Per Minimum Data Set Section G and GG with date of 1/19/23 states in part but not limited to the following: Balance during transitions and walking: moving from seated to standing position: not steady, only able to stabilize with staff assistance; Mobility: picking up object: the ability to bend/stoop from a standing position to pick up a small object: dependent- helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers required for the resident to complete the activity. On 4/11/23 at 11:40AM, ten residents were observed in the dining room, with no CNA or supervision. At 11:55AM, R61 was observed assisting residents and putting clothing protectors on residents. No staff observed in dining room at this time. At 12:20PM, V18 (Certified Nursing Assistant/CNA) came in the dining room to help serve lunch. V18 was interviewed regarding supervision in the dining room. V18 said there should be one CNA in the dining room during meals; however, we have to transport the residents back to their rooms after meals. There may not be supervision in the dining room when we are transporting people. There are some residents that need assistance during mealtimes as well. I do not feel as if one CNA is enough to supervise the residents.	S9999		

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S9999	Continued From page 9 At 1:10pm, it was observed to have six residents in the dining room with no staff present. At 1:20PM, R47 stopped this surveyor and asked if she could go back to her room. No staff present in the dining room at this time. On 4/12/23 at 2:50PM, V2 (DON) was interviewed regarding supervision. V2 said, my expectation of supervision during mealtimes is that a staff member is present throughout the entire meal while residents are in the dining room. If a resident is requesting to be transported elsewhere, they should notify another CNA or staff member to supervise while they are not present. 1.B. On 04/10/23 at 11:32 AM, observed R90's bed not in lowest position. R90 stated the remote to his bed doesn't work. R90 stated he is getting tired of calling them to ask for his bed to be adjusted. R90 stated he fell out of bed the other day while asleep, so they try to keep his bed low to the floor. R90 stated his bed should be lower but he can't adjust it. On 04/11/23 at 3:25 PM, observed R90's bed raised approximately 1.5 to 2 feet from the floor. Observed V30 (Licensed Practical Nurse/LPN) lower R90's bed manually from his foot board because his bed remote control was not working. Fall Log Received 04/11/24 from Facility Documents R90 had falls 12/01/22 at 10:27 AM, 12/07/22 at 10:27 AM, 12/24/22 at 10:00 PM, 12/28/22 at 7:33 AM and at 2:02 PM, and 04/02/23 at 10:52 PM. R90's current care plan documents he is at risk for falls with interventions including ensure (trade	S9999		

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name) a tool aid for picking up things that are out of reach, is within reach, educate resident to use (trade name) tool aid as needed, and use call light for assistance, and ensure the bed height is at its lowest position, Increased staff supervision with intensity based on resident need, resident is educated on using proper body mechanics when repositioning in bed, ensure floor mat is in place, be sure resident call light is within reach and encourage the resident to use it for assistance as needed. The residents prompt response to all requests for assistance.

R90's progress note dated 12/01/2022 at 09:57 PM documents writer was made aware by CNA (Certified Nursing Assistant) that resident was on the floor on the side of the bed. Fall was unwitnessed, and resident stated that he was trying to sit in the chair.

R90's progress note dated 12/24/2022 10:15 PM documents at approx. 10pm resident was observed by CNA laying on the floor. Resident stated he had a fall while trying to reposition for comfort.

R90's progress note dated 12/28/2022 07:45 AM documents at approximately 7:10 AM, resident was observed on the floor in prone position by staff. Resident stated he didn't fall but slid out of bed to the floor; at 02:15 PM CNA staff reported to writer that resident was on the floor, writer noted resident lying on the floor next to bed.

R90's progress note dated 04/02/2023 10:40 PM documents writer called to room and witnessed resident on hands and knees on the floor. Writer asked resident what he was trying to do, and he stated, I was reaching for something on my dresser and ended up on my hands and knees. I

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really didn't even fall. I never touched the floor fully my body didn't hit anything. The resident stated he was reaching for something on his dresser when he fell.

On 04/12/23 at 02:57 PM, V29 (Restorative Licensed Practical Nurse/Fall Coordinator) and V2 (Director of Nursing/DON) stated that staff needed to be educated on R90's specific needs and ensuring staff observe his care plan for fall interventions. V29 and V2 agreed that R90's bed should be in the lowest position. V29 stated if a resident is at risk for falls and their bed is not in lowest position as included in their fall interventions, they could fall, and anything can happen.

On 04/13/23 from 1:51 PM - 2:09 PM, V2 (DON) stated a root cause analysis should be completed after each fall. V29 (Restorative Licensed Practical Nurse/Fall Coordinator) stated R90 has a behavior of adjusting his bed with his remote. V29 stated this behavior would contribute to his fall risk factors as well as him attempting to reposition himself in bed and transfer himself. V29 stated R90 does need increased supervision based on his fall history which would include frequent every hour - hour and a half.

1.C. 04/10/23 11:50 AM, R92 was not in his room during resident screening and was later seen at the dining area sitting with about five other residents. No staff member noted in the dining area. Resident was awake and alert but unable to answer any questions.

04/11/23 at 10:05AM, R92 was observed in the dining area with other residents, there were no staff members in the dining area with the residents.

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04/12/23 11:45AM, R92 was observed in the dining area with other residents from 11:30AM to 11:45AM, there were no staff in the dining area or the nursing station.

Review of facility fall log showed that R92 had an unwitnessed fall in his room on 1/3/2023 with no injuries, the intervention for that fall incident was to increase staff supervision and redirect as needed.

On 3/21/2023, facility documented another unwitnessed fall in the resident's room with a head injury, was sent to the hospital and returned to facility with three staples to the back of his head.

Writer was alerted to patient's room by therapy staff. Writer observed patient lying supine on floor next to his wheelchair. Writer asked resident what happened. Resident stated, "I was reading my daily chronicles, one of them fell on the floor and I reached to pick it up, then I fell on the floor." Resident placed into bed with a mechanical lift. Head to toe body assessment done and noted 2cm cut to back of head and bleeding noted. Pressure and ice pack applied to back of head. bleeding stopped. (Trade Name) wound closure tape applied. No loss of consciousness. No complaints of pain voiced. Vitals taken: 145/66,62,17,98.0,97% O2 room air. Neuro checks initiated. Writer notified Hospice and ok to send to hospital for further evaluation. NP made aware. left voicemail for patient's son(s). DON made aware. (ambulance) called for pick up. (ambulance) arrived and pt exited facility on stretcher. will try again later to call son(s).

R92's medical record includes documentation,

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S9999	Continued From page 13 03/21/2023 07:29 PM: Resident alert and verbally responsive. Behavior calm and cooperative. Resident denies pain or discomfort at this time. Skin assessment completed revealing a laceration with 3 staples to back of head s/p fall. No swelling, drainage, or other s/s of infection at this time. Resident returned to a position of comfort with bed in lowest position and call light attached. Resident arrived back on the unit alert and in stable condition via ambulance. Neuro check WNL and all vitals stable. No signs nor complaints of any distress. Able to move all extremities. R92 arrived on the unit with three staples that was placed to posterior head and orders to leave in place for 7-10 days. Both (son) and NP made aware of arrival on unit and resident clinical situation. Monitor closely, frequent rounds, and all safety measures in place. Will continue to monitor. Facility policy titled Falls and Fall Risk, managing with revision date of 3/2019 states in part but not limited to the following: Policy Statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident-centered approaches to managing falls and fall risk: The staff will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. 2. R22 is a 79-year-old male who was admitted to the facility 11/16/2021 and has diagnoses that include: dementia, lack of coordination and a history of falls.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007843	A. BUILDING: _____ B. WING _____	C 04/13/2023

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S9999	Continued From page 14	S9999		

On 4/10/23 at 09:37 AM, R15 said one-time R22 came into her room, urinated in a cup, and left it on her table. Another time he came into her room and defecated on the floor and smeared it all over.

Facility Concern Form: dated 3/20/23 states R15 complained about another resident going into her room. Summary of Findings determined that the confused resident is in the same room down a different hall. This resident wanders, gets confused, and then goes into R15's room and starts to clean up or remove items that are unfamiliar. Resolutions signed by V1 Administrator) said that family of this resident was contacted and asked to find a dementia unit what would better meet the needs of the resident as he is unable to be redirected easily and is upsetting the alert residents.

04/12/23 04:18 PM, V7 (Assistant Administrator) confirmed the wandering resident to be R22 and said there were concerns with R22 going into R15's room and care plans were updated to reflect that provided redirection. His room was equidistant to R15's room, and there was at least one incident where he used her toilet and missed. We had to get housekeeping to clean it up.

Progress note dated 03/15/2023 at 12:34 PM stated: "This writer made several attempts and left [Voice Mail] messages on 3.14.23 and 3.15.23 to son of resident (R22) regarding his increased wandering. Writer will [follow up] with another phone call. [Social Services] will continue to provide therapeutic services as needed."

04/12/23 02:52 PM, V2 (DON) stated, I think given certain residents and staff attempts to do.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 15 The residents have the right to manipulate themselves. If a resident is cognitively impaired, rounding, supervision, meaningful activities, asking for family to be more active. We expect for the residents to be supervised by staff ideally at all times. According to our payroll-based journal (PBJ) we have enough staff to provide this supervision. (A)	S9999		