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	IL6005391	A. BUILDING: _____ B. WING _____	C 04/11/2023

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S 000	Initial Comments Investigation of Facility Reported Incident of March 24, 2023/IL158374	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 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 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest	S9999	**Attachment A** **Statement of Licensure Violations**	

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practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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.

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:

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Based on interview and record review, the facility failed to provide supervision to an intoxicated resident with a history of falls to prevent future falls, failed to investigate the source of an unwitnessed injury as a potential suicide attempt, and failed to update a resident's care plan to include new interventions for episodes of intoxication for 1 resident(R1) of 4 residents reviewed for accidents and supervision in the sample of 4. This failure resulted in R1 sustaining a fall on 12/19/22 resulting in a fractured left hip and sustaining a fall on 3/24/23 resulting in sutures and staples to the back of the head and neck.

Findings include:

R1's Minimum Data Set (MDS) dated 1/31/23 documented the following: Diagnoses of Heart Failure, Unspecified, Essential Primary Hypertension, Chronic Obstructive Pulmonary Disease, and Unspecified Atrial Fibrillation. R1's admission date was 09/30/22. R1's Brief Interview for Mental Status Score was 14, indicating R1 is cognitively intact. R1's Mood Indicators document little interest or pleasure in doing things, and feeling down, depressed, or hopeless, for 7-11 days in the 14 days look back period. R1 requires assistance of at least one staff member for bed mobility and transfers. R1 displayed no behaviors in the 14-day lookback period.

R1's Fall Risk Assessment dated 1/31/23 documented a score of 18, indicating R1 is at high risk for falls.

R1's Care Plan dated 2/1/23 listed a problem area, "Falls: Resident has risk factors that require

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monitoring and intervention to reduce the potential for self-injury." This problem area documented the following interventions: 12/29/22: "Xray left hip. Education related to drinking while outside the facility. Med (medication) times changed." 12/20/22: "Sent to ER." There were no fall interventions added for R1's 2/26/23, 3/24/23, and 3/27/23 falls. There were no interventions targeting toward keeping R1 safe from falls while intoxicated. There was no problem area nor interventions on the Care Plan addressing R1's possible suicide attempt on 3/24/23.

A Fax Worksheet IDPH (Illinois Department of Public Health) Notification Form dated 3/24/23 documented, "Time of incident: 4:15pm. (R1) returned a visit with family with no injuries noted at the time. At approximately 4:15pm, staff entered (R1)'s room, noting lacerations to his neck...When asked what had happened, (R1) who is alert and oriented, stated he tried to kill himself. (R1) was sent to ER (Emergency Room) for tx (treatment), investigation started per (facility) protocol, final follow up report to follow."

A Final Report document dated 03/31/23, submitted via fax to IDPH, stated, "This letter will serve as a follow up and final report to the initial report submitted on 03/24/2023 regarding an alleged suicide attempt involving (R1) .... On 03/24/2023, (R1) had returned from and outing with family (at) around 1:43 pm. (R1) was noted on the floor by staff. (The) Nurse assessed (R1), noting a scratch on his neck; (The) nurse cleaned (the scratch) and (R1) resumed (his) normal routine. (V8-Social Services Designee/SSD) checked in with (R1) (and) he told (V8) he had cut himself shaving, (and) reported to her he had fallen while out with his brother. (R1) was also

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noted to have an empty bottle of rum on his person. When asked if he had been drinking (R1) replied, 'Yes, I have.' At approximately 4:10 pm staff noted (R1) on the floor with blood on his face, neck, and shirt. (The) nurse was notified and she assessed (R1) noting, (a) laceration to (the) back of (the) head and neck. (V5 - Physician) (was) notified with (an) order given to send (R1) to (the) ER (for) eval(evaluation) and treatment. When asked what happened, (R1) stated, "I slit my neck with a razor knife." (R1) received 3 staples to the back of his head and 3 sutures to his neck." On 3/27/2023 (R1) spoke to (V1 - Administrator) and apologized for telling staff he slit his neck with a razor knife and that he was just joking. Investigation revealed that (R1) admitted he did not try to commit suicide and he was just joking, however per (R1) he had consumed alcohol while on an outing with family and that he was attempting to self-transfer from his bed to his wheelchair when he lost his balance and fell. Root cause (of fall): Drinking alcohol, causing unsteady gait, and attempting self- transfer from bed to wheelchair. New Intervention (added): Educate (R1) on the effects of drinking alcohol while out with family or friends. (V8 is) to follow (R1) three times weekly regarding (the) effects of drinking. (R1) is on a waiting list for an apartment..."

3/24/23 (ER) Physician Documentation noted, "(R1) was trying to get into bed and fell, causing cuts to face and scalp. Bleeding a lot. Was out with brother to local tavern during a day pass today. Wounds: #1. 1cm (centimeter) laceration. to left jaw. Skin closed using simple sutures. #2. 1cm laceration...to left jaw. Skin closed using simple sutures. #3. 2cm laceration...to scalp. Skin closed with three staples using staple gun. #4. 2cm ...laceration to face. Skin closed using

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simple sutures."

R1's Care Plan with a review date of 2/1/23 documented a problem area, "(R1) is noted to smell like alcohol and states 'I'm drunk' after returning from friends visit, (R1) continues to drink when out with his brother and friend." The following are the interventions for this problem area: 02/26/23: Education provided to (R1) about the facility being alcohol free after bringing alcohol into the facility again." Undated: "Education was provided to (R1) related to drinking while in the facility." Undated: "Education provided again to (R1) and brother related to drinking outside the facility and returning intoxicated, and the risk it has on the med(medications) (R1) is taking." Undated: "(V8) to remind (R1) of policy and procedures." There was no indication in this document that R1 was screened by a mental health professional for suicidal ideation or behavior, nor for the potential need for inpatient psychiatric care. There were no interventions related to offering R1 access to a substance abuse evaluation/treatment/AA (Alcoholics Anonymous). There were no interventions outlining keeping R1 safe when he is intoxicated. There were no interventions related to restricting R1's access to alcohol which he sneaks in. There were no interventions regarding holding any of R1's medications when he is intoxicated. There were no interventions related to the safety of R1's peers when R1 is intoxicated.

An SBAR (Situation, Background, Assessment, and Recommendation) Communication Form dated 12/19/22 at 1:45pm documented, "(R1) Fell in bedroom. (V4 - Physician) notified. See corresponding Nurses Note. (R1) Denies pain at this time. Recommendations-Monitor; change

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Verapamil and Plavix med(ication) times to 8:00pm with instructions to hold these med(ications) if (R1) consumes alcohol that day." A corresponding Nurses Note dated 12/19/22 at 1:30pm documented, "(R1) on LOA (Leave of Absence) with friend. When he returned, this nurse was summoned to his room with a report of a fall. Upon assessment, (R1) (was) noted to smell heavily of alcohol and was sitting on the floor on his buttocks with his feet pointed to(ward) the bed. (R1) stated he was trying to get in bed and his shoe slipped. (His) shoes were still on his feet and the floor was noted to be dry. No signs or symptoms of injury. (R1) was assisted up and to bed. Reeducated on the need to abstain from drinking alcohol related to his medications and the risk of falling. Resident did not respond verbally when asking if he understood. (The incident was) reported to management. Notified (V15 -Nurse Practitioner/NP) of the fall. Cardiac med(medication) times (were changed) to 8pm with instructions that if (R1) consumes alcohol that day, then cardiac meds need to be held that evening." A Nurses Note dated 12/19/23 at 2:00pm documented, "Assessed (R1) for pain, he denies pain at this time. He was sleeping. No other discomfort noted. "The next Nurses Note is dated 12/19/23 at 8:30pm "(Portable Xray Company) here to x-ray residents left hip. "There were no Nurses Notes to indicate what happened between 2:00pm and 8:30pm. A Physicians Order dated 12/19/23 and signed by V15 stated, "(Obtain) 2 view x-rays of left hip." An Xray Patient Report dated 12/19/23 at 9:21pm documented, "Acute left femoral neck (hip) fracture." On this report was handwritten at the bottom, "(Order received to) Send to ER for evaluation and tx."

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An ER Provider Note dated 12/20/23 documented,"(R1) is brought to the ER. Patient fell while trying to get back in bed, patient fell on the left hip. Xray revealed a left femoral neck fracture...Fell yesterday at the facility. Did not complain of pain at the time.... Alcohol use: Yes. Occasional binge."

On 04/05/23 at 8:45am, V1 (Administrator) was asked to provide the investigation for the above referenced incident. V1 stated she had not done a written investigation because she is fairly new to the position and did not realize she should.

On 04/05/23 at 9:10am, R1 was alert and oriented to time, place, and person. At this time, R1 had no sutures or staples to the head or neck. R1 stated he goes out with his brother and/or a friend usually once a week on weekends and may or may not drink alcohol during these visits, depending on his mood that day. R1 stated he does not have a problem with alcohol. R1 stated after being out of the facility with his brother on 12/19/23, when he returned, he fell during an attempted self-transfer. R1 stated initially he had no pain or other signs of injury, but as the day wore on, he began experiencing pain in his left hip, and an x-ray showed a left hip fracture. R1 denied being intoxicated at that time but did acknowledge he may have been 'buzzed.' R1 stated that on 3/24/23, he returned to the facility after being out with his brother and may have been 'buzzed' but was not intoxicated. R1 stated he did not fall or otherwise injure himself during this outing. R1 stated he does not recall if on either of these occasions staff searched his person upon returning to the facility. R1 stated early in the afternoon of 3/24/23, he fell in his room while trying to self-transfer from the wheelchair to the bed. R1 stated he sustained a

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small cut on his neck which staff cleaned and bandaged, but he was not otherwise injured. R1 stated later that same afternoon, he was ambulating in his room and fell against the nightstand, cutting his neck and the back of his scalp. R1 denied that he cut himself or told staff that he had cut himself and stated he would not have had anything to cut himself with. R1 denied having had a knife on his person. R1 stated he was sent to the local ER where his lacerations required sutures and staples. R1 stated he was not having issues with depression or suicidal ideation on 03/24/23 or since then.

On 4/5/23 at 1:00pm, V5 (RN/Registered Nurse), stated she was working 6am to 2pm on 3/24/23. V5 stated in the early afternoon, R1 returned from a visit with his brother. V5 stated she is not sure exactly when he returned, but she checked his person and clothing for alcohol, and there was none found, nor any weapons. V5 stated she recalled that she did not smell alcohol on R1, but her sense of smell isn't very good. V5 stated at the end of her shift at around 2:00pm, R1 was found on the floor by his bed and R1 said he fell as he was trying to get himself from the wheelchair to the bed. V5 stated R1 had a small cut to his jaw area which she cleaned and bandaged. V5 stated she assessed R1 and didn't see any other injuries. V5 stated she finished her shift and was relieved by V6 (LPN/Licensed Practical Nurse). V5 stated she later heard from other staff, she is not sure whom, that at about 4:00pm on 3/24/23, R1 cut his throat trying to kill himself, and that a knife was found in his pants pocket when the pants went to the laundry. V5 stated to her knowledge, R1 had no history of suicidal ideation or behavior. V5 stated she is not aware of any new interventions being added after 3/24/23 for R1 falling and/or the reports of him

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cutting himself while intoxicated. V5 stated the safety plan for R1 when returning intoxicated is to "Search him for alcohol when he comes back." V5 stated R1 is known to sneak alcohol into the facility and has been caught drinking in the facility.

On 4/5/23 at 1:50pm, V6 (LPN) stated she worked the 2:00pm to 10:00pm shift on 03/24/23. V6 stated she was told by V5 during shift report that R1 had been out that day with his brother drinking, and upon his return, fell in his room at about 2:00pm, causing a scratch to the jaw. V6 stated that around 3pm, she was notified that R1 was in his bed bleeding from the neck. V6 stated she observed three fairly deep, profusely bleeding lacerations to the neck and chin area, as well as a laceration to the back of R1's head. V6 stated R1 told her he didn't know how it happened. V6 stated R1 smelled of alcohol and his eyes were red. V6 stated the ambulance was called and she cleaned R1 up while they were waiting. V6 stated when R1 left in the ambulance, she called the emergency room with report and spoke to V16 (RN at Emergency Room). V6 stated after she got off the phone, one of the CNAs (Certified Nursing Assistant) told her that R1 reported to the CNA that he, "cut his neck with a razor knife." V6 stated she again called V16 to tell him what the CNA had reported. V6 stated V16 told V6 that R1 would receive a mental health evaluation while at the hospital. When V6 was asked about a safety plan for when R1 comes back home intoxicated, V6 stated, "We try to monitor him more frequently. He is usually up in his wheelchair in the dining room, or in his room sleeping it off." V6 stated R1 at times refuses to let nursing staff assess him when he returns, at times will not allow staff to search him, and sometimes the friend or family member with whom he has been

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out will drop him off at the front door and he will make his way back in unescorted, "and half the time we don't even realize he's back in the building." V6 stated when R1 returned from the ER right before the end of her shift, "We checked his vitals, did every five-minute check with him and let him sleep it off." V6 stated she assumed that R1 had the mental health evaluation while at the hospital. V6 stated when she returned to work the following day, V4 (Physician) had been in to see R1 and had discontinued the five-minute checks. V6 stated she is not aware of any new safety interventions initiated for R1 following the 3/24/23 incidents. V6 stated R1 is known to sneak alcohol into the facility and has been caught drinking in the facility. When asked if she thought R1's lacerations were self-inflicted, V6 stated in retrospect she is not sure.

On 4/5/23 at 2:30pm, V7 (CNA) stated she was working the 2:00pm to 10:00pm shift on 03/24/23 and was assigned to float between the halls. V7 stated about 4:00pm, she saw staff congregated outside R1's room. V7 stated she peeked in, saw R1's bloody neck, and asked R1 what had happened. V7 stated R1 shook head and said, "I slit my throat with a razor knife." V7 stated she doesn't think anybody else heard him say that. V7 stated she immediately reported this to V6 (LPN). V7 stated she has not heard R1 make any statements about suicidal ideation or attempts before or since that incident. V7 stated she is not sure if R1 got back from the hospital while she was still on duty. V7 stated when R1 goes out with his brother he frequently comes back drunk and agitated. V7 stated they have to check him to see if he has alcohol on him, but sometimes R1 refuses to let them check. V7 stated R1 is otherwise generally pleasant and cooperative, and she has not seen him become

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aggressive with peers, nor have peers verbalized being afraid of him. She has never witnessed him fall.

On 4/6/23 at 10:15am, V8 (SSD) stated she has been in the position about four weeks. V8 stated on 3/24/23, she worked from 8:00am to 4:00pm. V8 stated about 4:00pm, she was working with another resident on R1's hall, and heard staff say R1 has blood everywhere. V8 stated she looked in the room, where R1 was in bed. V8 stated she looked R1 over and he had three gashes to his neck and a small cut to the jawline which were bleeding profusely, and R1 was holding a towel to the area. V8 stated R1 told her he cut himself shaving. V8 stated she told R1 the cuts looked too deep for a shaving accident, and R1 stated, "That's how it happened." V8 stated she noticed the back of R1's head was bleeding. V8 stated V6 came in then and asked V8 what happened, and V8 showed her the cuts and V6 ran out to call an ambulance. V8 asked R1 if he had been drinking on his earlier outing and he said yes. V8 stated R1 said he fell while out and that caused his jaw wound. V8 stated the ambulance came a few minutes later. V8 stated she looked around the room and didn't see anything amiss or anything that R1 could have hurt himself with. V8 stated later staff found a bottle of alcohol in R1's room. V8 stated on Saturday 3/25/23, V8 worked a half day. V8 stated R1 was on every five-minute suicide precaution checks so while R1 was in the dining room, V8 watched him from V8's office. When asked what interventions V8 provided on 03/25/23, V8 stated she asked R1 if he was suicidal and R1 said no. V8 stated she did not do any formal assessment that day. V8 stated she has reached out to R1's friends and family members and told them alcohol use is dangerous for R1 because of the medications he

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is on and because R1 is a fall risk, but they all deny he has a problem, and R1 has told V8 that R1 is buying their alcohol on these outings. V8 stated sometimes they will drop R1 off at front door and he comes back in, and staff don't realize he is back. V8 stated she has discussed the dangers of mixing alcohol with medications many, many times with R1, and R1 always denies he has a problem. V8 stated during 3/27/23 Monday morning staff meeting, two days after R1 came back, V2 (Director of Nurses) told staff that R1 had not had a mental health evaluation while in the hospital. V8 stated she was very concerned that he needed one, as R1 has extremely poor judgement and safety awareness especially while drinking. V8 stated she brought up the possibility of R1 being seen by V11 (Advanced Practice Nurse in Psychiatry), but the consensus of staff was that V11 would not medicate R1 because of his drinking. V8 stated she did not discuss treatment for substance abuse or behavioral health with R1 until the morning of 04/06/23, which she stated was because V8 has only been in the position for four weeks and is just starting to get familiar with the residents.V8 stated she does take part in the Care Plan meetings, but V8 does not think there has been a Care Plan Meeting for R1 since she was hired. V8 stated she has not contacted any substance abuse or mental health treatment providers on R1's behalf. V8 stated she also thinks R1 might benefit from inpatient services at an out of state geriatric mental health program, but V8 has heard they have a waiting list and has not contacted them. V8 stated she does not believe staff routinely search R1's room. As far as a safety plan for R1, V8 stated staff "Try to watch when (R1) comes back in and then search him if he will let them." V8 stated she did a Mood Assessment on 3/27/23 and R1's result was a 10, with a score of 10-14

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indicating moderate depression. V8 stated her plan with R1 moving forward is to do one to one session with him three times per week for alcohol use education. When V8 was asked about her plan regarding R1's mental health, V8 stated she is not focusing on that because R1 does not outwardly show signs of depression. V8 stated she is not a licensed therapist or social worker. V8 stated R1 wants to move to an apartment, but this is not a feasible goal given his care needs and community history of drinking and becoming homeless.

A Mood Assessment dated 3/27/23 documented a score of 10, indicating R1 experiences moderate symptoms of depression, such as feeling down or depressed, or having little interest or pleasure in doing things, 7 to 11 days in the 14 days prior to the date of the assessment.

On 4/6/23 at 10:55am, V1 (Administrator) stated that Fall Investigations are internal Quality Assurance (QA) documents and therefore cannot be shared during the survey process.

On 4/6/23 at 11:00am, V9 (Corporate Quality Assurance RN) was interviewed regarding R1's falls, with V9 using the QA documents the facility would not allow this surveyor to access. The following is R1's fall history from his 9/30/22 admission to 4/6/23 according to V9's verbal account:

12/19/22 at 1:30pm: R1 was found on the floor of his room in a sitting position. R1 stated he was trying to self-transfer from the wheelchair to the bed, and R1 stated his shoes slipped and he fell. R1 was noted to be wearing appropriate footwear and the floor was dry and clutter free. The root cause of the fall was determined to be altered

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S9999	Continued From page 14 mental status related to alcohol use. R1 initially denied pain but at around 2:00pm, R1 started to complain of left hip pain so (V15/NP) ordered a portable x-ray, which showed an acute left femoral fracture, for which (V15) ordered R1 to be sent to the emergency room, and R1 was sent out at 8:45pm. The care plan intervention added was to, "Educate (R1) about not using alcohol on outings." 2/26/23 at 3:20pm: R1 was coming back in the building from the patio during smoke break when R1 fell. R1 had no injuries and did not require hospitalization. The root cause was determined to be alcohol impairment. The intervention added to the care plan was to "Ensure (R1) is safe to participate in smoking act." 3/24/23 at 1:30pm: R1 was found lying on the floor of his room, R1 stated he was trying to self-transfer from the wheelchair to the bed. R1 sustained a skin tear to left side of cheek, which was cleaned and bandaged. R1 was not sent out and no other injuries were noted. The root cause of the fall was determined to be impairment due to alcohol use. The care plan intervention added was to "Educate and encourage R1 to use his call light for transfers." 3/24/23 at 4:10pm: R1 was found in bed bleeding from injuries to the neck, back of head, and jaw. R1 stated he did not know what happened. A fall was presumed but later information indicated the injuries could have been self-inflicted. The root cause was determined to be alcohol intoxication. R1 was sent to the emergency room. The new care plan intervention added was to educate R1 about alcohol use. 3/27/23 at 2:30pm: R1 was found on the floor of	S9999		

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his room after attempting to self-transfer from wheelchair to bed. R1 stated his boots were unlaced and he tripped. The root cause was determined to be R1's boots being unlaced resulting in R1 losing balance and falling. R1 was not injured and not sent out. The new care plan intervention added was for R1 to request assistance with transfer and to wear proper footwear.

On 4/6/23 at 1:10pm, V16 (Emergency Room RN) stated R1 was treated there on the afternoon of 3/24/23. V16 stated facility staff called with report and stated R1 sustained neck injuries due to a fall. V16 stated a few minutes later, staff called back and reported that R1 reported feeling suicidal, but nothing was said about the injuries potentially being self-inflicted. V16 stated R1 was alert and oriented, and R1 stated earlier in the day he went out and had drinks then came back and fell. V16 stated R1 adamantly denied suicidal ideation and self-injurious behavior. V16 stated R1 had superficial bleeding injuries to the neck and the back of the head. V16 stated that R38's injuries appeared consistent with a fall. V16 stated the Emergency Room Physician evaluated and treated R1, cleaning, suturing, and stapling the areas. V16 stated the Physician asked R1 about suicidal ideation and self-injurious behavior, which R1 denied, so R1 was therefore not referred for a Mental Health Evaluation. V16 stated he does not recall telling facility staff that R1 would get a Mental Health Evaluation before he was sent back.

A Physicians Encounter Note dated 03/25/23, authored by V4 (Physician) documented, "(R1) got a laceration on the left cheek that was sutured at the emergency room across the street yesterday, they (staff) thought he had a knife, and

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he did it himself. He does not talk about that, but it has been sutured and it looks good...He will not tell me, either he does not know, or chooses not to tell how he got that laceration...He said he did not do it, so they (staff) want to know if he needs to be on suicide watch. I think we will take him off one on one but again I am available 24/7."

On 4/6/23 at 1:40pm, this surveyor contacted the office of V15 (Advanced Practice Nurse/Collaborative Associate of V4). Office staff stated V15 was not available for the next week due to attending the funeral of a family member.

On 4/6/23 at 1:45pm, V4 confirmed V15 will be unavailable all week due to a death in the family. V4 stated he and V15 have been following R1 since R1's admission to the facility. V4 stated R1 has multiple chronic health issues. V4 stated facility staff have made him aware that R1 is leaving the facility to drink. V4 stated R1 drinking on his medications is dangerous, and R1 has had several falls at the facility related to drinking. V4 stated the facility contacted him about R1's incident around 4:00pm on 03/24/23 and V4 was told R1 first stated he fell, then later R1 had stated he cut his neck. V4 stated staff never reported that R1 may have had a knife or that a knife may have been found in R1's pants. V4 stated R1 should have been referred for a mental health evaluation and a substance abuse evaluation when he returned on 03/25/23. V4 stated he has left standing orders for some of R1's medications to be held on the days when he drinks, and facility staff should be notifying him or V15 every time R1 returns to the facility under the influence. V4 stated the facility should have a safety plan for how to deal with R1 coming back intoxicated. V4 stated when R1 returns after he has been drinking, R1 should have constant one

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S9999	Continued From page 17 on one supervision for safety. On 4/7/23 at 9:40am, V10 (CNA) stated she always works weekends. V10 stated R1's friends and family generally pick him up after lunch around 12pm to 1:00pm, but the time they bring him back varies, sometimes not until 6:00pm. V10 stated sometimes he will be dropped off at the front door and staff are not aware he is back in the building. V10 stated she was working from 6am to 6pm on 3/24/23. V10 stated R1 had gone out with family after lunch and returned that afternoon extremely intoxicated and smelling strongly of alcohol. V10 stated she checked R1 for alcohol in his clothing, but there was none, and R1 had no weapons. V10 stated when R1 is drunk he usually gets loud, sometimes he is pleasantly drunk, but he is always quicker to get frustrated, and V10 stated she has witnessed R1 lunge at staff and be verbally aggressive toward staff. V10 stated she has never seen R1 hit staff or peers or be verbally aggressive to peers. V10 stated sometimes R1 will just go to straight to his room and go to sleep until dinner. V10 stated that afternoon R1 "was different," he was in his room and was quiet and withdrawn. V10 stated about 4pm, V10 was doing pre-supper rounds. V10 stated she went by R1's room, looked in and saw R1 lying in bed and there was blood all over his neck. V10 stated there was another CNA with her, she cannot recall which one, and that CNA ran to get V6 (LPN). V10 stated she asked R1 what happened, and he said he didn't know. V10 stated R1 was not very alert and was slurring his words. V10 stated R1 didn't seem to be aware he was bleeding. V10 stated she noted there was no blood anywhere in the room except on R1's neck, and there was no blood on the floor as if R1 had fallen. V10 stated V6 came to the room and was helping R1, and the ambulance came soon after.	S9999		

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V10 stated when R1 comes back staff try to get him to let them look through his clothing, usually he will let them, and they ask him how many drinks he's had. V10 stated she has never seen any weapons or knife on R1, but he does try to sneak alcohol into the building. V10 stated R1 has never seemed to have mood issues or depression and has never said anything about suicidal ideation. V10 stated when R1 is sober, staff remind him he's not supposed to be drinking on his medications. V10 stated the safety plan for when R1comes back drunk is that staff try to monitor him and check on him more. V10 stated none of R1's peers seem afraid of him, but sometimes they complain he has the TV on too loud. V10 stated the only friend R1 has is R2, they sit at the same table for meals. V10 stated R1 gets around via wheelchair and requires assistance of one staff member and a gait belt for transfers. V10 stated R1 is mostly independent with other activities of daily living. V10 stated during morning care, staff give R1 a disposable razor for shaving and then take the razor back when he is done. V10 stated this is the procedure for all residents, so it would be highly unlikely R1 had access to a disposable razor. V10 stated R1's room is searched periodically for alcohol.

On 4/7/23 at 10:15am, R2 was alert and oriented to person, place, and time. When asked if there are any peers whose behavior concerns him, R2 stated yes, and named R1. R2 stated he was previously R1's roommate and he is aware that R1 has purchased knives through an online retailer and had them shipped to the facility. R2 stated he believed one was intercepted by facility staff right after it was delivered, and it was sent back to the retailer. R2 stated he was not sure if R1 ever had knives on his person or in his room.

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R2 stated R1's family takes R1 out to the bar and R1 comes back drunk and R1 yells at the CNAs. R2 stated staff have to search R1 for alcohol when he comes back. R2 stated he has never witnessed R1 trying to hit staff or peers.

On 04/07/23 at 11:00am, V2 (DON) stated she has been in the position about three weeks. V2 stated on Friday 3/24/23 she worked 8:00am to 4:00pm. V2 stated R1 had gone out on a visit with his family after lunch and returned intoxicated. V2 stated she was notified by staff at about 4:50pm that R1 had been sent to the emergency room after falling. V2 stated staff did not say anything at that time about R1 possibly having cut himself. V2 stated when she returned the following Monday, 3/27/23, "She heard secondhand from one of the CNAs that he tried to kill himself." V2 stated she was told by staff that V4 (Physician) came in on 3/25/23 to evaluate R1 and had discontinued R1's every five-minute check. V2 stated staff discussed R1 in the Monday morning staff meeting, and the consensus of the group was that R1 had told different stories to different people, that R1 said he fell and got hurt when out with the brother, that he later said didn't know what happened, and later still told one of the CNAs apparently that he cut himself, but staff found no weapons in the room. V2 stated staff present determined that the plan going forward would be that V8 (SSD) would meet with R1 three times a week to provide alcohol education. V2 stated she reviewed the patient discharge packet R1 returned with (from the hospital) and noted that R1 had not received a mental health evaluation, but V2 did not call the hospital for details as to why or try to arrange a mental health evaluation for R1. When asked what interventions she personally had provided for R1 on 3/27/23, V2 stated she "had a casual

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conversation with (R1), it's not like I filled out a piece of paper on him or anything." V2 stated she does not think R1 made a suicide attempt, "Maybe he did, but I think he probably fell." V2 stated she has made no changes to R1's nursing plan of care since 3/24/23. V2 stated she has tried talking to R1 about the dangers of alcohol use with his medications, but R1 always denies having an alcohol problem. V2 stated she did not hear reports from any staff members that R1 might have had a knife. V2 stated staff search R1 for alcohol when he comes back from visits, and she has not heard of him refusing. V4 stated the areas of injury to R1 had the sutures and staples removed and are now healed. V2 stated she did not investigate the incident. V2 stated R1 has never seemed depressed or verbalized suicidal ideation. V2 stated she has never been aware of R1 threatening or harming peers.

On 4/7/23 at 11:45am, V1, (Administrator) stated she worked 8:00am to 4:30pm on 3/24/23. V1 stated R1 went out with his brother and a friend after lunch and returned intoxicated. V1 stated after 4pm, staff notified her that R1 had been sent out due to having several scratches or lacerations on R1's neck. V1 stated staff initially reported R1 fell, but later reported that he told a CNA he "Slashed his neck with a razor knife." V1 stated she then went to R1's room and noted there was no blood anywhere on the floor, and the bed had already been stripped. V1 stated she searched the room, and no weapons were found. V1 stated she now thinks R1 may have had a suicide attempt. V1 stated on 3/25/23, she was in the building about 7:30am and, "checked on" R1, he "seemed ok" and denied he tried to hurt himself. V1 stated R1 said he was sorry for saying that he tried to kill himself, and that he had been joking. V1 stated she called R1's brother and his friend

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S9999	Continued From page 21 who had taken him out the day before, and they denied any problems related to the outing and denied R1 was drinking. V1 stated she believes R1 could be depressed. V1 stated currently, staff are monitoring R1 by doing visual checks on him "as often as they can," and CNAs are checking on R1 each time they pass his room. V1 stated the safety plan for when R1 returns after drinking is to check him for liquor, ask him if he drank, ask him if he needs help, make sure he has on the proper footwear, and remind him to use the call light if he needs help. V1 stated shortly after she was hired in November of 2022, R1 received a package from an online retailer containing a knife, which V1 mailed back, and V1 stated R1 has received no other packages. V1 stated she told R1 he can't have a knife at the facility. V1 stated no staff members have said anything to her about finding a knife in R1's room, in his clothing, or in the laundry. V1 stated R1 has on one occasion slapped a staff member while intoxicated, and has not been physically aggressive toward peers, but V1 has heard him yelling, "Shut the f**k up" to peers while in the dining room. During Monday morning staff meeting on 3/27/23, the possibility of R1 being seen by V11 was brought up, but V11 only visits once a month unless a resident needs to be seen emergently, and V1 did not feel R1 was emergent. V1 stated R1 did not get a mental health evaluation while at the hospital and acknowledges the facility did not make attempts to obtain a mental health evaluation/treatment, or a substance abuse evaluation/treatment for R1. On 4/7/23 at 12:30pm, V3 (RN Corporate Regional Director of Operations) stated the facility currently does not offer behavioral health or substance abuse services via contractual providers, but she can check to see if there are	S9999		

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S9999	Continued From page 22 contractual providers available in the area. On 4/7/23 at 1:40pm, V12 (Laundry/Housekeeping Supervisor) stated today she checked with all her staff, and none reported ever finding a knife in any of the resident's laundry or room. V12 stated her staff have however found empty alcohol bottles in R1's laundry. V12 stated all her staff are aware they should notify her or V1 immediately if weapons are found. On 4/11/23 at 9:15am, R1 stated he went out with family on 4/8/23 but did not drink. R1 stated since last speaking with this surveyor, V8 (SSD) has spoken to him about a referral for substance abuse and mental health treatment, and R1 is considering it. R1 stated he realizes alcohol can negatively interact with his medications, and that he should not be bringing alcohol into the facility as it is against facility policy. R1 confirmed that he had ordered a knife online and that the facility intercepted it and sent it back. R1 stated he then at some unknown point ordered another one and had it shipped to a post office box where a friend picked it up and brought it to him. R1 stated it was a pen knife, and staff found it on him and confiscated it. R1 stated he cannot remember when this occurred. On 4/11/23 at 9:40am, V1 stated she has still not started an investigation into R1's possible suicide attempt. When asked why, V1 stated since V4 saw R1 and discontinued R1's suicide watch on 3/25/23, V1 didn't feel there was any need to at this point. On 4/11/23 at 10:30am V14 (Care Plan/Minimum Data Set Coordinator) stated she was hired about one month ago and works three days a week.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005391	A. BUILDING: _____ B. WING _____	C 04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON REHAB & HCC	1409 NORTH MAIN STREET BENTON, IL 62812

(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 23 V14 was interviewed by phone as V14 was not in the facility on this date. V14 did not have access to the Care Plan during the interview but stated new fall interventions should be added to the Care Plan after every fall. V14 stated she had not added a problem area related to alcoholism and was not aware that R1 may have attempted suicide, and therefore had not added that as a problem area either. On 4/11/23 at 11:30am, V1 stated she is not aware of any staff finding a pen knife on R1, and she does not think the friend he mentioned has had any contact with R1. A Prohibited Drug/Alcohol Policy dated 10/10/22 stated, "(The facility) has a responsibility for all residents safety. Drugs and other substances not prescribed by a resident's treating physician can cause dangerous and life-threatening conditions. (The facility) prohibits the presence or use of illegal or non-prescribed drugs in the facility or anywhere on the premises. The facility also prohibits the presence or use of alcohol in the facility or anywhere on the premises." A Comprehensive Care Planning Policy dated 7/20/22 documented, "The Care Plan shall be revised as necessary when the needs/problems and care and services specified in the plan of care no longer reflect those of the resident...Comprehensive Care Plans shall strive to describe...specialized services or specialized rehab services...All intervention entries should include the date the care intervention was initiated by the staff as well as the date the intervention was added to the Care Plan if added after the original Care Plan date."	S9999		

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 24 "A"	S9999		