| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S 000 | Initial Comments<br><br>Complaint Investigation: #2349380/IL166541 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.1210b)<br>300.1210d)4)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>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.<br><br>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:<br><br>4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. :<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These requirements were not met as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure residents were free from neglect by not providing as needed monitoring/visual checks for 1 of 5 residents (R3), reviewed for neglect in the sample of 5. This failure resulted in R3 falling out of bed at an unknown time and being found deceased with face being disfigured and gash on the right side of his forehead.<br><br>Findings Include:<br><br>R3's Face Sheet, undated, documents R3 has the following diagnoses: Neurocognitive Disorder, COPD (Chronic Obstructive Pulmonary Disease), Atrial Fibrillation and Presence of a Cardiac | S9999 | | |

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| S9999 | Continued From page 2<br>Pacemaker.<br><br>R3's Progress Note, dated 9/15/2023 at 8:35 AM by V6, Licensed Practical Nurse (LPN), documents she was called to R3's room by a Certified Nurses Assistant (CNA). R3 was observed on the floor face down next to his bed. Resident had no response, pulse or respirations. Time of death was determined by two nurses at 8:20 AM.<br><br>R3's Death Certificate, documents a date of death of 9/15/23, no time provided, and the cause of death was listed as Hypoxia with COPD.<br><br>R3's Minimum Data Set (MDS), dated 8/2/23, documents R3 requires assistance with bed mobility, transfers, toileting and is frequently incontinent of bowel and bladder.<br><br>R3's Care Plan, dated 2/10/21, documents R3 has an ADL (Activities of Daily Living) deficit and to assist with care.<br><br>The Facility Investigation documents the following: Date of incident: 9/15/23 at 8:35 AM with a report date of 9/20/23. Nursing staff found R3 deceased beside his bed on 9/15/23 at 8:35 AM. Per R3's plan of care, the resident preferred to stay in bed most of the time or refused to get out of bed and often liked to sleep until noon. R3's bed was in low position and the call light was within easy reach of the bed but had not been activated.<br><br>The Facility's Timeline of Events documents the following: 9/15/23 at 12:00 AM: R3 was lying in bed; 1:15 AM - R3 was in bed watching TV, awake, yelled at staff; 8:30 AM 1st CNA (V11) passing breakfast drinks and found resident, 1st | S9999 | | |

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(V4, Former LPN)/2nd (V6, Registered Nurse (RN) nurse called/arrived to room; 8:36 AM - 3rd (V12) nurse arrived in room, 2nd (V13) CNA arrived went to get mechanical lift sling, 4th (V7) nurse arrived.

The Facility Camera Footage Review from 9/14/23 - 9/15/23 for R3's room documents the following information: 9/14/23 at 5:52 PM: V14, Former CNA, entered R3's room, exited room at 5:54 PM, 9/15/23 at 8:03 AM: CNA (no name) observed entering R3's room.

V4, Former LPN's, written statement, no date or time, documents the following: At approximately 12 AM, she opened the bathroom door, noted that R3 was sleeping and snoring. He showed no visible signs of pain.

V4, Former LPN's, written statement, dated 9/15/23, documents the following: When doing her rounds at midnight on 9/15/23, R3 was lying in bed on right side. R3 was resting quietly with no signs or symptoms of distress. R3 has a preference not be disturbed during the night. V4 had no personal knowledge of the event until she was called to R3's room at 8:30 AM.

On 11/15/23 at 12:54 PM, V4, Former LPN, stated she checked on R3 on 9/15/23 around 12 AM, he was in bed. V4 stated she did not check on him again through the night until she was called to his room that morning (9/15/23) around 8 AM. V4 stated when she entered the room, R3 was lying on the left side of his bed, face down and full rigor mortis had set in, when they turned him over "it was the worst thing I've ever seen, his face was blue and smashed in." It was established that he could've fallen but "you could tell he had been there a while." V4 stated he was

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| S9999 | Continued From page 4<br><br>incontinent at times and particular about what kind of care and when he wanted care. V4 stated R3 was not nice and didn't want messed with during the night. V4 stated she was suspended for a week and then fired because they (facility management) said she didn't do her rounds. V4 stated "it was weird because it's normal protocol that the nurse notifies the coroner's office of a death, but V1, Administrator, and V2, DON, stated they were going to do it, but she doesn't think they did. V4 stated their normal standards of practice was that residents that needed assistance were checked on every 1 1/2 to every 2 hours by the nurses and/or CNAs.<br><br>V4's Separation Report documents the following: Date and time of incident: 9/15/23, last day worked: 9/15/23; Termination date: 9/25/23; nature of separation: violation of company policy, dishonesty with investigation; facts of the incident: employee was on shift the night that an incident happened. Employee was asked to write a statement of what happened and the statement that was wrote did not match video footage that was found on cameras.<br><br>V6's, (RN) written statement, undated, documents the following: V6 was passing medications to a resident in the dining room at 8:30 AM when a CNA approached her and said come to R3's room now. V6 observed R3 face down on the floor. V6 immediately called V2, Director of Nurses (DON) and V1, Administrator, to come to R3's room.<br><br>On 11/15/23 at 9:15 AM, V6, RN, stated she was working when R3 was found deceased. V6 stated she began work at 7 AM, went to take care of another resident, which took a little while and then sometime between 8:30 AM and 9:00AM, she | S9999 | | |

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found R3 deceased on the floor. V6 stated he was found face down on his stomach with his arms above his head. V6 stated when she found him she assessed him with another nurse and found that he did not have a blood pressure or pulse. V6 stated when she tried to move him he was "stiff." V6 stated she was written up for neglect and insubordination, she didn't agree with it but she signed it anyway because she needs her job. V6 stated she was told to write her nurse's note and then Administration handled the rest. V6 stated she is not aware of when R3 had been checked on last.

V6's, RN, Disciplinary Report documents the following: Date of incident: 9/15/23 at 7:00 AM; nature of incident: carelessness/negligence of duties, insubordination; facts of incident: employee was on shift and failed to do her rounding at the appropriate times.

V7's, LPN, written statement, dated 9/15/23 at 10:44 AM, documents the following: V7 was called into R3's room indicating that R3 was deceased and that they needed to get him off of the floor. Upon walking into R3's room, V7 saw R3 lying on his back next to the right side of his bed. R3 appeared to be deceased and his face was disfigured with blood and a gash on the right side of his forehead.

On 11/16/23 at 10:35 AM, V7, LPN, stated when she entered R3's room, unsure of time, he had already been turned onto his back. R3 was incontinent, had a gash to the left side of his forehead and his face was disfigured, appeared smashed inward. V7 stated she assumed R3 had fallen due to the way he had been found. V7 stated she did not notice any other areas and his injuries were primarily to the left side of his

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head/face. V7 stated she did not normally take care of R3 so she isn't sure what his level of care was.

V11, CNA's, written statement, dated 9/15/23, documents the following: she came into the building around 5:50 AM for her shift at 6:00 AM. She went through her group getting people up and ready for breakfast. While waiting for other third aid, she was passing drinks for the residents who eat on the hall and upon opening R3's door, she noticed R3 face down on the floor. She called out his name with no answer. She exited the room to look for the nurse. A nurse was notified on her way to find the nurse on his group. R3's nurse was notified around 8:30 AM.

On 11/15/23 at 12:40 PM, V11, CNA, stated the morning R3 was found deceased, they were supposed to have three CNA's but only two showed up. V11 stated she got her group of residents ready and was passing out drinks. V11 stated R3 likes her so she decided to go in to see if he wanted to get up and get dressed for breakfast. V11 stated when she entered R3's room, he was on the floor face down, she called his name but he didn't answer so she went and got the nurse. V11 stated she went into the room with the nurse and helped to roll him over but forced herself not to look at his face because she knew "it was bad." V11 stated when they rolled R3 over, he was stiff. V11 stated she is not aware of the last time R3 had been visually seen or checked on. V11 stated R3 was incontinent but they couldn't tell if it was because he would take himself to the bathroom, not pull his pants down all the way and would get it on him, but he would also be in bed and be incontinent on himself. Stated he would refuse care for certain people, he had his favorites and he liked her so she took

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| S9999 | Continued From page 7<br>care of him.<br><br>V13, CNA's, written statement, dated 9/15/23, documents the following: V13 overheard the nurses say someone was unresponsive so she went to see if she could help. V13 saw R3 face down on the floor and went to get a mechanical lift sling, but once they rolled R3 over, she stepped back and let the nurses handle it.<br><br>V14, Former CNA's, written statement, dated 9/15/23 at 9:42 AM, documents the following: worked 2 PM - 10 PM and 10 PM - 5 AM; worked the 200 hall, rooms 211-222. 2-10 PM shift, V14 started rounds to put R3 to bed, about 8:30 PM, V14 changed R3 and he sat in his chair. R3 put himself to bed. On the 10 PM -5 PM shift at 1:15 AM, V14 started her rounds, went into R3's room, R3 was lying in bed, awake, the TV on and R3 was facing the television. R3 yelled at V14 to get out of his room, V14 left his room and had no further interactions with R3.<br><br>On 11/15/23 at 8:40 AM, V1, Administrator, stated there were concerns with R3's death and the length of time that had passed before he was found deceased.<br><br>On 11/15/23 at 9:05 AM, V1, Administrator, stated the last time R3 was checked on prior to being found deceased was at midnight by V4, Former LPN. V1 stated there were staff that were disciplined because of the incident.<br><br>On 11/15/23 at 9:05 AM, V10, Regional Nurse Consultant, stated it varies as to how often residents are checked on. V10 stated it depends on if the resident is clinically stable, independent and what their preferences are. V10 stated if they are clinically unstable, they are checked on more | S9999 | | |

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| S9999 | Continued From page 8<br>often/frequently.<br><br>On 11/15/23 at 11:10 AM, V1, Administrator, was asked what is the standard of practice with rounding/checking on the residents is in the facility. V1 stated it's determined through their plan of care, if someone was incontinent then the expectation would be to check them every 2 hours. V1 stated R3 required some assistance with ADLs but often refused assistance and didn't like to be disturbed at night. V1 stated she did not notify the coroner. V1 stated their normal practice is that the nurse on the hall notifies the coroner.<br><br>On 11/15/23 at 12:35 PM, V16, CNA, stated R3 needed encouragement with ADLs but didn't like to be bothered. V16 stated he would normally check on R3 between 6 AM and 7:30 AM to see about breakfast and if R3 wanted to get up, then again when they picked up trays after breakfast, then again before lunch around 11 AM and 11:30 AM, then again when they picked up the lunch trays and then again before the end of his shift. V16 stated R3 was incontinent, was able to get out of bed on his own, but still needed checked on. V16 stated they check on all the residents at least every 2 hours.<br><br>On 11/15/23 at 1:30 PM, V18, Deputy Coroner, stated their office was notified of R3's death by a nurse, unsure of whom, but not that there had been any recent falls, injuries, etc. When surveyor told him that V4, Former LPN, and V7, LPN, had confirmed that R3 was found face down on the floor with facial disfigurement and bloody, V18 stated the office was not notified of that information.<br><br>On 11/15/23 at 2:35 PM, V17, Advance Practice Nurse (APN), stated she had concerns with the | S9999 | | |

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facility in regards to R3's death. V17 stated the facility did an investigation and R3 was found face down deceased, he had fallen at sometime and wasn't found right away, there were concerns on how long it had been since he had been checked on. V17 stated her biggest concern with the facility is regarding to the quality of care being provided to the residents. V17 stated the majority of her time during her visits are spent fielding complaints from residents and family on their care. V17 stated it has gotten worse over the past month. V17 stated all the residents that reside in the facility are there because they need care, and she agrees that the standard of practice is to check on all residents at least every couple (2) hours. V17 stated she signed R3's death certificate under the supervision of her attending, V19, Medical Director/R3's Physician, who was out of town at the time, and they agreed that R3's cause of death was Hypoxia related to COPD. V17 stated she was notified by the facility about the concerns with the length of time from when he was checked on last until he was found deceased and that he possibly had fallen but not full details of how he was found.

On 11/15/23 at 10:05 AM, V1, Administrator, stated they do not have a formal policy on rounding/monitoring/supervision, it is determined according to the resident's plan of care.

The Prevention of Abuse, Neglect and Exploitation policy, dated 10/21/22, documents it is the policy to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Neglect means failure of the facility, it's employees, or service providers to provide goods

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| S9999 | Continued From page 10<br>and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.<br><br>(A) | S9999 | | |