Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016570	A. BUILDING: ______ B. WING ______	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELDS OF GENEVA	0N801 FRIENDSHIP WAY GENEVA, IL 60134

(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
S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: I of IV: 300.1210a) 300.1210b) 300.1210d)3)5) 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 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. (Section 3-202.2a of the Act) 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to identify an area of pressure prior to it becoming unstageable in a resident (R27) at high risk for pressure injury. This failure resulted in R27 needing to be hospitalized with osteomyelitis (bone infection) which required antibiotics. This applies to one of three residents reviewed for pressure in the sample of 12.

The findings include:

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The facility face sheet for R27 shows diagnoses to include adult failure to thrive, pressure ulcer of the sacral region and osteomyelitis of the sacral region and was admitted into the facility on 9/15/23 after a hip fracture. The facility assessment dated 12/7/23 shows R27 to have severe cognitive impairment and requires moderate assistance from staff for all activities of daily living. The facility scale for predicting pressure risks completed on admission, dated 9/15/23 shows R27 to be at high risk.

The skin evaluation dated 9/21/23 shows no areas of concern to the sacral area of R27's body.

The nursing progress note dated 9/27/23 for R27 shows a note stating R27 [has developed an unstageable pressure injury to her sacrum]. The measurements of the pressure injury were recorded as 4 by 8 CM (Centimeters) with 75% slough (dead cells in the base of a wound) that was yellow and a red perimeter around the wound.

On 12/13/23 at 1:10 PM, V3 (Wound Care Nurse) said R27 was admitted to the facility for rehab after a hip fracture. V3 said R27 developed a facility acquired unstageable pressure injury to her sacrum. V3 said R27 was seeing an outside wound clinic for this wound and was sent from the clinic to the hospital when it became infected.

On 12/14/23 at 9:00 AM, V3 said she expects the staff to find a pressure injury before it becomes unstageable.

On 12/14/23 at 9:15 AM, V2 (Director of Nursing) said a pressure injury should be reported to the

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nurse before becoming unstageable.

On 12/14/23 at 10:03 AM, V9 (R27's Physician) said R27 has a pressure injury to her sacrum and treatment to a wound should begin as soon as it is found. V9 said finding the wound is dependent on the cooperation of the resident and any pre-existing conditions.

On 12/14/23 at 10:17 AM, V11 (Certified Nursing Assistant) said R27 is always compliant with her care.

On 12/14/23 at 11:00 AM, V7 (Registered Nurse) said a wound should be found by staff prior to it becoming an unstageable wound. V7 said R27 is compliant with her care.

The facility assessment dated 12/7/23 for R27 shows no rejection of care has been observed.

The Physician Progress note dated 11/15/23 shows R27 was seen after her re-admission into the facility after a hospital stay. The note shows she was treated for an infected pressure skin injury and osteomyelitis to her sacral area pressure injury. R27 is to continue with intravenous antibiotics.

The facility care plan dated 9/18/23 shows to monitor/document/report any changes in skin status.

The facility policy with a revision date of April 2018 for pressure ulcer/skin breakdown shows nursing staff will assess and document a resident's significant risk factors for developing pressure ulcers.... The nurse will describe and document the following: full assessment of pressure sore, pain assessment, resident's

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mobility status....

"A"

Statement of Licensure Violations: II of IV:
300.1210b)5)
300.1210d)6)

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.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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 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 observation, interview, and record review the facility failed to ensure a resident was assessed for safety prior to the use of a motorized wheelchair for 1 of 2 residents (R6) reviewed for safety in the sample of 12. This failure resulted in R6 being sent to the emergency room and receiving 30 stitches to the right lower leg.

The findings include:

R6's face sheet printed on 12/14/23 showed diagnoses including but not limited to dementia, cognitive communication deficit, altered mental status, anxiety, osteomyelitis (bone infection), absence of right toe, foot pain, and history of falls. R6's facility assessment dated 11/20/23 showed moderate cognitive impairment. The assessment showed substantial/maximal staff assistance needed for toilet transfers and the use of a walker for ambulation.

R6's activities of daily living care plan showed an intervention dated 11/17/23 for: "TRANSFER-The resident is able to transfer with 1-assist, gait belt, walker."

R6's impaired cognitive function care plan showed an intervention dated 11/26/23 for: "Cue, reorient and supervise as needed."

On 12/13/23 at 8:50 AM, R6 was lying in bed and covered with a light blanket. R6 was awake but sleepy. R6 was slightly confused and refused to be interviewed. At 10:43 AM, V17 (R6's daughter) was at the bedside and R6 was asleep. V17 stated R6 had a recent toe amputation and is on IV antibiotics for an infection. V17 stated R6 had a motorized wheelchair in her room for a few days and accidentally ran it into the side of the

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bed. V17 said the right lower leg was ripped open and she had to go to the emergency room for stitches. V17 said R6 is somewhat confused at times, but especially recently, due to the toe amputation and medications being given to treat the infection and pain.

On 12/14/23 at 10:36 AM, R6 was seated in her room next to her bed. R6 lifted her right pant leg and a C-shaped area with multiple sutures was observed on the right lower leg. A baseball size dark, purple bruise was covering the area. The leg wound was at the same level as the metal mattress platform on her bed. R6 was asked what happened and stated she took herself to the bathroom using a motorized wheelchair. R6 said she got off the toilet and pushed the button on the wheelchair. R6 said she ran super hard into the side of her bed and hit a metal rail. R6 said she had been using the wheelchair for a couple of days, including back and forth to the group dining room. R6 said her daughter brought it in for her and the staff knew she was using it.

R6's progress note dated 12/6/23 stated: "At 19:25 (7:25 PM) heard resident scream. CNAs and RN rushed to check on resident and noted resident on motorized wheelchair next to bed, stated she hit her right leg on the bed. Resident just came out of bathroom, stated she ran into the bed while using motorized wheelchair. Resident (complains) of severe pain to right shin. When checked blood gushing out on a laceration. Applied pressure to stop bleeding. Resident screaming in pain, does not want anybody look under her pants due to tightness of clothing rubbing into wound. RN needed to cut pants open to look at injury. Noted large flap of skin and bleeding a lot. Applied pressure to stop bleeding. Notified MD and ordered for resident to be sent to

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hospital for eval and treat. 911 was called for transport. Daughter (name omitted) and notified of incident. DON/ADON notified of incident. Paramedics took resident to hospital at 19:45 (7:45 PM)."

On 12/13/23 at 2:47 PM, V12 (Certified Nurse Assistant/CNA) stated R6 rammed her motorized wheelchair into the side of her bed and needed sutures. V12 said she had no idea how long it was in her room or why she was using it. V12 said R6 was able to walk with one assist prior to the incident and had no need for a wheelchair.

On 12/13/23 at 2:59 PM, V13 (CNA) stated he had no knowledge of a motorized wheelchair being used by R6.

On 12/14/23 at 8:20 AM, V15 (Occupational Therapist) stated R6 should not be using a motorized wheelchair. She (R6) had one in her room that her daughter had brought into the facility and R6 ran into the bed with it. V15 said she thought the chair had been in the room about 24 hours before the incident occurred. V15 said residents need an assessment done prior to use to ensure they can operate it safely. V15 said R6 should have definitely been trained on it first. V15 said the wheelchair was taken away as soon as the therapy department found out about the incident. V15 said R6 is sleepy and not always alert. V15 said R6 is confused at times and cannot be wheeling herself around safely. V15 said R6 can stand and pivot therefore there was no need for a motorized wheelchair. V15 said it would not have been recommended for use until it was determined she could operate it safely and that has never been done. V15 said it is not appropriate for R6 to use a motorized wheelchair now or prior to the incident. R6's family just

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S9999	Continued From page 8 brought it in one day and she was never assessed on it. On 12/14/23 at 8:35 AM, R6's motorized wheelchair was in the corner of the therapy gym. A piece of paper was taped to the back of it with handwritten instructions on how to use the chair and a contact phone number for the family member. V15 stated the paper was put there by her family member when the chair came it. V15 said it is irritating the nursing staff never told the therapy department she had it in the room. She needed training on it before they let her use it. On 12/14/23 at 10:47 AM, V17 (R6's daughter) stated she did bring the motorized wheelchair in for her mother. V17 stated R6 was able to get herself in and out of it alone. V17 said it was in R6's room for about one week. R6 used it several times and even went out on a doctor's appointment in it. V17 said her and another family member showed R6 how to use it. V17 said they left an instruction manual for the staff to use. V17 said she was told staff would be sure to tell the therapy department she had it and also show R6 how to use it. V17 said she was not sure if that was ever done, and the wheelchair has been taken out of the room since the incident. V17 said the staff all knew R6 had it. The wheelchair was in her room and in plain sight. On 12/14/23 at 10:57 AM, V16 (Physical Therapist) stated R6 is very hazy and lethargic. She would not be able to operate a motorized wheelchair safely. R6 has safety deficits, is weak, and lethargic at most times. Residents need to be assessed first by the therapy department. Check off forms are used to assess for safety going forward, backward and turning. Residents need to be assessed for the ability to judge distances and	S9999		

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obstacles. They need to be able to get on and off it correctly. The assessment ensures the resident is safe to use the motorized chair appropriately. V16 stated R6 was never assessed prior to her using the chair and it was never reported to the department that she had it in her room. V16 stated R6 was physically able to transfer in and out of a chair by herself, but not mentally able to do it safely by herself.

On 12/14/23 at 11:17 AM, V2 (Director of Nurses) stated the incident with R6, and the chair never should have happened. Staff have no idea how long the motorized wheelchair was in her room prior to the incident. It is not appropriate for family to just bring in equipment as they feel. There is the risk the resident may not be ready to operate it. R6 was never assessed or trained to use it safely before she jumped on it. It should never have been left in the room and staff should have removed it. R6 was never reviewed to use it safely. Nursing staff should have been aware it was in there. Nursing probably just assumed therapy okayed it. No one realized she would just jump on it and take off.

R6's emergency room note dated 12/6/23 at 9:04 PM states: "Patient presents from (facility name), was in her electric wheelchair when she lost control and hit the bed with her right shin. EMS reports an approximate 6-inch avulsion to the right shin."

R6's most recent skin/wound note dated 12/13/23 at 8:00 AM showed: "1. Dressing changed to RLE (right lower extremity) laceration "C" shaped 17 cm (centimeters); area around the sutures/laceration gently cleansed with wound cleanser and pat dry. Dry gauze placed and secured with paper tape. No drainage, no c/o

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pain, no odor. Sutures in place. Peri wound with ecchymosis appears fragile. Currently the flap appears to be adhering and viable."

The facility's Motorized Mobility Device (MMD) Use in Health Centers policy revision dated 10/31/20 states under the resident assessment due to medical condition section: "A. In the event a resident has a medical condition that would interfere with the resident's ability to operate a MMD, nursing or therapy team members, including therapy vendors providing services to the resident, in consultation with the administrator, shall perform an assessment to determine whether the resident demonstrates evidence of sufficient skills/ability to follow all community safety rules and operate the MMD safely. The assessment shall be included in the resident's medical record."

The facility was unable to provide a Motorized Wheelchair/Cart Skills Assessment form for R6.

"B"

Statement of Licensure Violations III of IV:
300.615e)
300.615f)

Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information
e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background

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check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)

f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility failed to check the Illinois Department of Corrections website. This applies to 10 of 10 residents (R27, R39, R41, R94, R95, R97, R98, R99, R144, R145) reviewed for background checks in the sample of 10.

On 12/13/23 at 10:40 AM, V10 (Community Outreach Coordinator) said she has never checked the Illinois Department of Corrections website for any resident being admitted to the facility. V10 said she did not have access to this website.

On 12/13/23 at 10:42 AM, V1 (Administrator) said she was not aware the Illinois Department of Corrections website needed to be checked for the residents unless they had previous history of convictions which would show up on the background check.

R27's face sheet shows she was admitted to the facility on 12/6/23. No Illinois Department of Corrections check was completed.

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S9999	Continued From page 12 R39's face sheet shows he was admitted to the facility on 11/29/23. No Illinois Department of Corrections check was completed. R41's face sheet shows she was admitted to the facility on 11/30/23. No Illinois Department of Corrections check was completed. R94's face sheet shows he was admitted to the facility on 12/4/23. No Illinois Department of Corrections check was completed. R95's face sheet shows she was admitted to the facility on 12/4/23. No Illinois Department of Corrections check was completed. R97's face sheet shows she was admitted to the facility on 12/2/23. No Illinois Department of Corrections check was completed. R98's face sheet shows she was admitted to the facility on 12/7/23. No Illinois Department of Corrections check was completed. R99's face sheet shows he was admitted to the facility on 12/8/23. No Illinois Department of Corrections check was completed. R144's face sheet shows he was admitted to the facility on 12/13/23. No Illinois Department of Corrections check was completed. R145's face sheet shows he was admitted to the facility on 12/11/23. No Illinois Department of Corrections check was completed. The facility policy with a date of 2/3/23 shows the purpose of the identified offender's policy and procedure is to ensure the safety of all residents	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELDS OF GENEVA	**0N801 FRIENDSHIP WAY GENEVA, IL 60134**

(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 13	S9999		

of our community.

"AW"

Statement of Licensure Violations IV of IV:
300.661

Section 300.661 Health Care Worker Background Check
A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility failed to have a completed employee background check for one of ten staff reviewed for healthcare worker background checks.

The findings include:

On 12/14/23 at 12:00 PM, V1 (Administrator) said she had supplied the surveyor with all the background check information she had. This surveyor asked for the records for V5 and V1 replied, "He is not our employee, he is contract staff." V1 said they had reached out to the company that supplies the kitchen staff and never received anything from them. V1 said she had no records of V5 ever having a background check being completed. V1 said it is very important to have completed background checks on all employees in the facility ensure the residents safety.

The facility policy with a review date of 12/1/21 for background screening and reference checks shows it is the policy to ensure the safety and

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S9999	Continued From page 14 security of residents and team members and to ensure the integrity of the workforce by screening the staff member. "AW"	S9999		