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	IL6000244	A. BUILDING: _____ B. WING _____	C 08/05/2024

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LOFT REHAB & NURSING OF NORMAL	510 BROADWAY NORMAL, IL 61761

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S 000	Initial Comments Complaint Investigation: 2465823/IL175967	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)3) 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 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		

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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:

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.

These Regulations are not met as evidenced by:

Based upon observation, interview and record review, the facility failed to ensure the safety and supervision of a resident with a history of self-harm and attempts at suicide. These failures affect one (R1) of three residents reviewed for behavioral health services on the sample list of three. R1 put a plastic bag tightly over R1's head resulting in emergency transport to the hospital, previously R1 was found on 5/20/24 with the call light cord wrapped around her neck.

Findings include:

R1's medical record documents the following: 5/21/2022 R1's medical record shows R1 was seen in the hospital for self-harm attempts. On 5/23/2022 R1's care plan was updated with behaviors of attention seeking with attempts to self-harm (suicidal ideations). This care plan

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states R1 is to have all corded accessories removed from room for safety and to have a call bell instead of corded call light.

R1's 6/01/2023 Psychiatric visit note documents R1 was seen for a follow up for mood disturbance. The note lists diagnoses of BPSD (Behavioral and psychological symptoms in dementia) including hallucinations, depression, and suicide intention threats in the setting of UTI (urinary tract infection).

R1's 5/20/2024 R1 was found by staff with call light cord wrapped around her neck as documented in nursing progress note dated 5/20/24 which states that around 12:25am R1 had gotten herself up to bathroom and back to bed. R1 had put the bathroom call light on but when V13 (C.N.A/ Certified Nursing Assistant) entered the room, R1 was already back in bed. V13 noticed R1 had the call light cord wrapped around her neck. V13 called for writer. V13 removed the cord, no injury from this act by R1. When R1 was asked why she wrapped the cord around her neck. R1 stated "to kill myself, I want to die". V2 (Director of Nursing), R1's medical doctor and POA (power of attorney) notified and R1 sent out for psychiatric evaluation. (No new interventions were documented on R1's care plan or noted in her medical chart as a result of this incident.)

R1's 5/26/2024 psychiatric visit note documents R1 was found by staff with her call light wrapped around her neck and that she has a history of this behavior in the past. Staff stated they removed R1's call light at that time and gave her a bell to use. R1 has been increasingly more irritable including having verbal arguments with roommate.

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R1's 7/10/2024, R1 was sent to hospital after placing plastic bag over head, while at the nurse's station, in an attempt to self-harm as found in hospital emergency department nurse note. This note states R1 presented to ED (emergency department) via EMS (emergency medical service) with police escort for complaints of suicidal ideations. R1 states she tried to wrap a call light cord around her neck and tied a garbage bag around her throat and staff had to poke holes in it to take it off. R1 told EMS she "didn't want to breathe anymore". Per EMS report, pt's (patients) bp (blood pressure) was low 90's over 60's with a MAP (mean arterial pressure) of 66- IV (intravenous) established en-route and fluids given.

R1's 7/14/24, hospital discharge records stated that R1 presented to local ED via ambulance for suicide attempt at 6:37pm on 7/10/24 and was held on a psych hold with 1 to 1 observation until discharge back to facility at 7:07 pm on 7/14/24.

R1's care plan with a print date of 7/24/24 has new intervention entered on 7/20/24 stating all plastic garbage bags removed from resident's room.

On 7/24/24 at 12:15pm R1 observed sitting in dining room in wheelchair, R1 stated she does not feel her normal self today but is "okay". R1 states she doesn't recall any hospitalization and that I must have the wrong person. R1 asked if she would like to talk to me later and she stated "yes". On 7/24/24 at 1:45pm resident lying in bed in R1's room. R1 stated "I remember you". R1's room is the very last room, next to exit door furthest away from nursing station. Observed mounted TV above R1's head and R1's

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roommate's call light cord attached at wall behind R1 bed and in reach of R1. On 7/29/24 at 9:45am in R1's room TV mounted over the bed with looped unsecured cord hanging down above the head of R1's bed. A reading lamp and radio with cords was sitting on the bedside. The cords were not secure and were accessible to R1. One large plastic bag was on the floor by R1's bed and another large plastic bag was on the bedside table. A plastic bag was in the trash bin under the sink. There were multiple plastic grocery bags on the roommate's side of room and within R1's reach. A call light cord was attached to the wall above head of bed between R1's bed and the roommate's bed. R1 able to reach up and grab roommates call light. During this survey R1 was noted to be propelling self around the facility without difficulty in her wheelchair.

On 7/29/24 at 11:25am, V12 (Psychiatric Physician Assistant; PA-C) stated that R1 attempted suicide in May of this year by wrapping a call light cord around her neck. V12 states she was told the call light was removed and R1 given a bell but did not inform her that R1 had a roommate or that there were still corded items in the room. V12 states that subsequently on 7/10/24 R1 placed a plastic bag over her head to "stop breathing" per R1. V12 states she saw R1 on 7/18/24 and R1 stated she felt ignored and was attempting to get attention. V12 states these attempts should be taken seriously by staff as any attempt could result in death as R1 has a long history of self-harm behaviors.

Facility policy titled Behavioral Health Services dated 12/5/2022 states that employees should be educated for meeting the behavioral health needs of the residents. This education would include behavioral interventions. This policy does not

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document who is responsible for training the staff as well as who is responsible for implementing and monitoring these interventions. Facility policy titled Suicide Prevention with an implemented date of 5/1/22 states the facility is to act quickly and appropriately if a resident expresses any thoughts of suicide.

On 7/29/24 at 9:55am V8 (housekeeping) stated she is aware of R1's restrictions to not have corded call light or trash bags in room. V8 also indicated she has inquired more than once to upper management regarding R1 having a private room as R1 has access to roommate's belongings including plastic bags, corded accessories, and corded call light.

On 7/29/24 at 10:20, V1 (administrator) states he was alerted that R1 had put a bag over her head in front of the nurse station and certified nurse and nurse responded immediately to remove the bag. V1 states a call was placed to 911 to have R1 sent to the hospital. V1 stated R1 was conscious but unresponsive to staff.

On 7/29/24 at 10:45am V6 (LPN/Licensed Practical Nurse) stated she witnessed R1 at the nurse station with a plastic bag over her head attempting to pull bag tight around her neck. V6 states she witnessed certified nursing assistant (C.N.A./Certified Nursing Assistant) rip open plastic the bag on R1's head. V6 states she is not aware of R1 having any prior attempts of self-harm.

On 7/29/24 at 11:16 AM, V2 Director of Nursing stated R1 has a diagnosis of Parkinson's Disease. V2 stated due to her (R1's) Parkinson's Disease her gait is limited. She (R1) has behaviors of self-harm. In May she was found

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with a call cord around her neck. We took hers out. Additional corded items were removed. R1's roommate has a call light that is attached to the table. There should be no cords in her room or garbage sacks. V2 stated she went in on Friday and there were no cords in her room. V2 stated the housekeeper told me today that there were incontinence brief bags in her room. V2 stated the CNAs put it there as a makeshift garbage sack. It should not be in there.

On 7/29/24 at 11:45am V9 (certified nursing assistant; C.N.A.) and V10 (C.N.A.) that are assigned to R1's hall stated they were not aware of any precautions for R1. V11 (RN/Registered Nurse) assigned to R1 stated she knew nothing as it's her first day as agency nurse.

On 7/29/24 at 12:36 PM, V3 (SSD/Social Service Director) stated she heard about R1 putting the call cord around her neck but cannot recall how or when. V3 states it was discussed in morning meeting which included therapy, V1, V2, V5, and V8 present. The intervention was to remove all corded items out of R1's room including corded call light as they were identified as a hazard to R1. V8 would have removed these items, The same people also concluded after R1's attempt with a plastic bag, that garbage bags be removed from room as they also are a hazard for R1. V3 states that R1 can toilet without assistance most of the time.

On 7/29/24 at 12:53 PM, V5 LPN MDS CPC stated that we discussed R1's putting the cord around her neck. The interventions of corded accessories not being in her (R1) room and a call bell instead of a corded call light was already on her care plan. There has been a lot of room moves. V5 stated it was most likely not removed

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from the new room. V5 stated they educate staff in multiple ways including in-services and mass email. V5 does not have documentation of any education.

On 7/29/24 at 1:24 PM, V2 Director of Nurses stated R1 was found with the cord wrapped around her neck. V2 stated there was an intervention already in place for R1 to not have any corded accessories or call light in room. V2 stated there was a call light in the room when she wrapped the cord around her neck 5/19/24. V2 stated she sends out emails to staff about facility and resident updates but has no verification method in place. V2 indicates the C.N.A.'s have access to the resident's electronic Kardex for individual resident interventions but there is no alert to notify them of any change made. V2 states the floor nurses are responsible for updating C.N.A.'s on any resident care plan changes but she has no way of knowing if this was done. V2 states there was "word of mouth" education but denies having documentation.

On 7/29/24 at 2:26pm, V13 (certified nursing assistant) stated that on the evening/overnight shift of 5/19/24- 5/20/24 she was working on the east hall when the nurse alerted her that R1 had wrapped the call light cord around her neck. V13 states R1 did not appear to be in distress or show any signs of change in behavior after incident. V13 states that floor nurse had the cord removed for R1's neck at the time V13 entered R1's room. V13 states she did not see any marks on R1's neck nor heard her coughing or complaining of having any respiratory issues. V13 states the nurse had R1 on 15 min checks and that V13 personally removed R1's call light from her room and gave her a bell to use. V13 confirmed it was R1's personal call light and not her roommate's

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S9999	Continued From page 8 call light she removed. V13 stated R1 was residing in the same room she currently resides in at the time of the incident. On 7/29/24 at 2:33pm V14 (RN) states on the evening/overnight shift of 5/19/24- 5/20/24 she was entering R1's room to administer R1's medications when she saw R1 sitting on her bed pointing at her neck where V14 states R1's call light was wrapped around it. V14 states R1 was conscious and did not appear to be having breathing difficulty at any time. V14 states she immediately removed the cord from R1's neck and after making sure R1 was not harmed, she placed her on 15 min checks and called and notified the DON. (B)	S9999		