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S 000	Initial Comments Complaint Investigation 2487887/IL178653	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1610a)1) 300.1630a)1) 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	S9999		

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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)

Section 300.1610 Medication Policies and Procedures

a) Development of Medication Policies

1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.

Section 300.1630 Administration of Medication

a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents.

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S9999	Continued From page 2 1) Medications shall be administered as soon as possible after doses are prepared at the facility and shall be administered by the same person who prepared the doses for administration, except under single unit dose packaged distribution systems These regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that the medications were safely locked up in the treatment cart when not in use to prevent tampering and accidental hazard; failed to ensure that resident medications were not left at bed side for two residents (R9 and R10); failed to ensure that adequate supervision is offered to one resident (R2) in the sample reviewed for falls. This failure affected R9 and R10 whose medications were left at bedside without physician order, and R2 who had a fall resulting in a laceration to the head. This has the potential to affect all 163 residents residing in the facility. Findings include: On 10/15/24 at 10:17am, R8's bed noted to be placed in high position and not in good working condition. R8 stated I (R8) cannot get out of the bed; I do not want to fall. When this observation was shown to V5, V5 stated the bed control is broken and I will have to let the maintenance department know because R8 can fall off of the bed. V5 did not know when the bed had been broken, the beds are not supposed to be this high. Broken beds are to be reported to maintenance for repair. V5 stated I am just seeing this now as you are speaking about it.	S9999		

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On 10/15/24 at 10:23am, R9 noted in bed and noted on the over bed side table a medication cup with one pill capsule, which V5 LPN (Licensed Practical Nurse) identified as Gabapentin 400mg. V5 stated the night shift nurse is supposed to give that at 6am this morning. V5 stated that the nurse must have left it there. The surveyor asked V5 what the facility policy and professional standard regarding medication administration is. V5 stated that the nurse should have made sure the medication was swallowed and no medication should be left at the resident's bed side unless on self-administration of medication program. At 10:25am V5 stated I know what the medication is, it is for neuropathic pain.

At 10:30am, on R10's bed side dresser two medication cups noted with medications, a total of five tablets. V7 LPN (Licensed Practical Nurse) assigned to R10 stated I (V7) did not give this type of medication this morning. And I (V7) don't know what the medications are. The surveyor then asked for V2 DON (Director of Nurses) to be called to the floor. At 10:35am, V2 identified three tablets of the medications to be Flexeril and the remaining two as Gabapentin. V7 stated the night nurse must have left them there because she did not give R10 any medication that look like this.
R10's order summary report showed that R10 has a physician order with a starting date 10/07/24 for Cyclobenzaprine HCL (Flexeril) oral tablet 10mg give 1tablet by mouth one time a day for pain and Gabapentin capsule 300mg (milligram) give 1 capsule by mouth one time a day for pain. Each medication was scheduled to be administered one time a day at 9:00pm (2100).
R10's MAR (Medication Administration Record) showed documentation that this medication was

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administered at the scheduled time.

At 10:42am, R13 observed in bed, and a blood draw (collection) needle noted visible to the hallway on the over the bed table. V23 CNA (Certified Nurse Aide) who was present in the room at the time of observation stated that the nurse must have left it there (referring to the blood draw).

At 10:45am, when shown to V7 (LPN). V7 stated I (V7) did not put it there and I (V7) don't even know what it is and who left it there. R12 stated one of the nurses must have left it there it's for my IV (Intravenous) site. Pointing to the right arm.

At 10:48am, V2 stated the facility staff both the CNAs and the Nurses are to make rounds at least every couple of hours at least 2hrs and the rounds includes getting these things (blood draw inserting collection set) out of the resident rooms. It is safety issues. If seen it should be removed.

On 10/23/24 at 4:10pm, V2 (Director Of Nursing) presented a copy of Department of health and Human Services Center for Medicare and Medicaid Services print out on Medication Storage and Labeling task that documented that medication and biologicals should be secured (locked) in storage locations that includes but not limited to medication carts. And a Daily Rounds sheet that indicated that med carts should be locked. V2 stated the facility does not have a medication storage policy but this print out guidelines are what the facility follows.

R2's medical record showed that R2 was originally admitted to the facility on 11/01/2021 and the latest admission date is documented as 09/22/24. Listed diagnosis include but not limited

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to Fracture of unspecified part of neck of left femur, initial encounter for closed fracture, weakness, unsteadiness, need for assistance with personal care, Wernicke's encephalopathy, encounter for surgical after care following surgery on digestive system, unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety.
R2 had un-witnessed fall on 09/13/24 with injuries that includes a Fracture of unspecified part of neck of left femur. R2 returned to the facility on 09/22/24 and had an unwitnessed fall on 09/26/24 with injury, laceration to the head. R2 was sent to the local emergency room for fall and laceration to the head.

On 10/25/24 at 11:20am, R2 observed in the dining room on a wheelchair. R2 was unable to recall what happened on both fall incidents of 09/13/24 and 09/9/26/24.
R2's Medical Record Progress noted date 09/26/24 timed 3:02pm (15:02) showed V16 documentation describing what happened to R2. V16 documented that she was summoned to (R2's) room, observed R2 on the floor lying on the left side, small laceration noted to the left side of the head with small amount of bleeding noted. Area cleaned with normal saline (NSS) and dressing applied and bleeding stopped.

On 10/15/24 at 3:16pm, V14 CNA (Certified Nurses Aide) stated that she was the CNA for R2 on the day of the fall of 09/13/24. V14 stated that R2 was walking with the rolling walker in the hallway, and she (V14) noted R2 slumped to the floor before she (V14) could get to R2.

On 10/16/24 at 11:39am, V16 stated that I (V16) was on duty when the CNA (referring to V17)

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called me at around 3pm. V16 stated that I (V16) was going to make my last round at the end of the shift when the (V17) called me to come and see R2 because R2 was on the floor. When I got there R2 was on the floormat. R2 bed was in a low position because R2 was on fall precaution. I (V16) and other CNA got R2 up into bed, full assessment was done, there was a skin tear on the left side of the head, and it was bleeding, I (V16) applied pressure dressing with 4x4 did the vitals and neuro checks was done. We (referring to staff) got R2 comfortable, and I (V16) called the doctor and the family. R2 was sent to the hospital. When asked who found the resident on the floor. V16 stated V17 the 3pm to 11pm CNA found R2 when she was making her shift change rounds. V16 stated that the staff did not know when R2 fell, and I (V16) was at the nurse's station when I was called.

On 10/16/24 at 11:57am, V18 (CNA) stated that yes, I was the morning shift CNA (Certified Nurses Aides), I had left the floor when R2 was found on the floor. When asked about R2 during the morning shift, V18 stated that I (V18) can't give you accurate description on how R2 was before the fall, I (V18) cannot recall anything before they said R2 fell. The surveyor asked whether R2 needs help/ supervision with ADLs (Activities of Daily Living), V18 replied I (V18) don't know. ADLs is very wide and I cannot recall.

The surveyor asked again what care they rendered to R2 (referring to the day of incident. V18 stated I don't know, I cannot recall. The surveyor asked V18 where R2 was when you left the floor. V18 stated I (V18) don't know. V18 then walk away from the surveyor.

On 10/16/24 at 3:30pm to 3:40pm, V22

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(Physician) stated that he (V22) is familiar with R2. V22 stated that R2 had fall incidents, R2 was sent to the hospital, had fracture and had surgery. V22 stated that R2 has Dementia and if they have dementia, they are not going to call for help they just get up and go because they don't have good minds. And we cannot restrain them. They need assistance to walk. The nursing home does not have the staff capacity to supervise them. They cannot use restrain; in the hospital we are allowed to restrain. The surveyor asked V22 about the second fall incident,V22 stated Yes, I'm aware. The surveyor asked V22 in your professional opinion and clinical opinion whether the level of supervision in the facility was appropriate for R2. V22 stated that is why I (V22) said they should follow their policy. They (facility) has a policy and they need to follow the policy. I (V22) think they follow it. There is no video. I (V22) don't think anyone can answer that question.

On 10/17/24 at 1:14pm, V1 (Administrator) stated that the nursing staff are expected to know the residents' needs as they care for them (residents). Provide services and care according to their plan of care. The staff are to make rounds every two-hour paying attention to the ADLs (Activities of Daily Living) and individual needs. V2 (Director Of Nursing) stated that no sharp objects should be left at the bedside and medication are not to be left in the resident room without an order to do so.

The facility Self-Administration of Medications by Residents with no date documented that the policy will be encouraged if it is desired by resident, safe for he resident and other residents of the facility, ordered by the attending physician and approved by the interdisciplinary team. Listed

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procedure includes but not limited to a physician order is obtained to self-administer medications.

The facility policy on Medication Administration dated 07/11 documented that the purpose of this policy is to administer all medication safely and appropriately to aid residents to overcome illness, relieve illness, relieve, and prevent symptoms, and help in diagnosis. Listed procedure includes but not limited to place needles and syringes in sharps container and remain with the resident to ensure that the medication is swallowed.

The facility policy on Guidelines Standard Supervision and monitoring dated 5/17/23 documented that the purpose of this policy is to emphasizes a proactive intervention promoting enhance physical and psychosocial well-being. The facility recognizes supervision and guidance to the resident is essential part of nursing care in which standard approaches are successful in meeting the resident's physical and psychosocial needs.

The facility presented a copy of Department of health and Human Services Center for Medicare and Medicaid Services print out on Medication Storage and Labeling

The facility policy on Incident/Accident Facility Responsibility presented with no date documented that all documentation is to be kept in the investigation of incident binder in the DON's office divided into reportable versus nonreportable incident.

The facility Accident Incident Reporting Policy version 080317 documented that the purpose of this policy is to ensure that accidents and incidents that occur with residents are identified,

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S9999	Continued From page 9 reported, investigated, and resolved. To provide a database to study the causes of accidents/incidents and to aid in implementing corrective actions to prevent reoccurrence when possible. (B)	S9999		