| 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>Facility Reported Incident of 8/27/24/IL177679<br>Complaint Investigation 2417267/IL177832 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations (1 of 3)<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<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 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.

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.

These regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to safely transfer a resident (R1) for 1 of 4 residents reviewed for safety in the sample of 6. This failure resulted in R1 falling, and hitting her head on the oxygen concentrator. R1's head laceration required 6 staples and 2 sutures for closure of the wound, in the emergency department.

The findings include:

On 9/10/24 at 10:05 AM, R1 was in wheelchair, being pushed to her room by a family member. There was dried blood and 6 stables on the top of R1's head, in her hairline. There was dried blood and scabbing along the staple line. The surveyor asked R1 if her head was sore and how it happened. R1 said her head hurt real bad when it first happened, but it was starting to get a little better. R1 said she has to take pain medication for the pain some days. R1 said on 8/27/24 she had taken a nap after lunch. R1 said she couldn't remember the CNA's (Certified Nurses Assistant) name. (Through investigation CNA identified as

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V13). R1 said the CNA came in to help her get up. R1 said she sat up on the side of the bed. R1 said V13 did not use a gait belt. R1 said the wheelchair was positioned to her right, parked near the foot of the bed, facing where she was seated. R1 said she stood with the walker in front of her and all she had to do was pivot to the right and sit down in the wheelchair. R1 said V13 was behind the wheelchair when she was pivoting and was not touching her. R1 said she doesn't really know what happened, but she lost her balance and fell forward. R1 said she didn't pass out or anything like that. R1 said she just fell forward and couldn't stop. R1 said she fell face first and hit her head on the oxygen tank (concentrator). R1 said there was blood everywhere and she was so scared. R1 said she went to the emergency room and they put staples and sutures in her head. R1 said sometimes her legs get weak and she loses her balance. R1 said there's a gait belt right there, pointing to a gait belt hanging on the wall, near her closet. R1 stated, "I don't know why they weren't using it. They didn't use it before I fell, but they do now. If they don't use it, then I'm supposed to remind them."

R1's Diagnosis/History printed 9/10/24 showed diagnoses to include, but not limited to: chronic kidney disease, morbid obesity, anxiety, insomnia, persistent atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, generalized weakness, and other abnormalities of gait and mobility.

R1's facility assessment dated 8/12/24 showed she was cognitively intact; had no behaviors; and required partial to moderate assistance to sit, stand, and transfer from the bed to chair.

R1's Care Plan initiated 1/28/24 shoed R1 was at

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risk for falls due to new surroundings and poor balance. This care plan also showed R1 required limited/extensive assistance of one (staff member) for ADL (Activities of Daily Living) tasks due to weakness and poor balance. The interventions included, but were not limited to: Assist of 1 for all transfers. Use gait belt and walker.

R1's Resident Incident Report showed the Fall occurred on 8/27/24 at 4:45 PM. This form showed R1 was transferring from the bed to the wheelchair with the CNA (V13), walker and gait belt. This document showed, "(The) patient was in the standing position and turning around to sit in the wheelchair. Patient suddenly leaned forward and fell head first into the oxygen concentrator sitting on the floor next to her bed. CNA unable to stop patient from falling. Laceration noted to frontal area of head/scalp. Excessive bleeding noted. Pressure immediately applied to laceration. Skin tear noted to left forearm - 1.5 cm (centimeters) x 4 cm, skin approximated and dressing applied per protocol... Unable to assess laceration well... transported to ER for evaluation and treatment..."

R1's Incident Followup Report printed on 9/3/24 showed, "...Resident admitted to [local hospital] for (atrial fibrillation with rapid ventricular response). Resident has 2 sutures and 6 staples and plan is to return to facility."

On 9/10/24 at 9:22 AM, V7 (LPN - Licensed Practical Nurse) said R1 is alert and oriented. V7 said R1 is aware of what is happening around her and can express her needs. V7 said before R1 fell, therapy had been working with her and she was a "super easy 1 assist for transfers." V7 said R1 does get very anxious. V7 said she was

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working the night R1 fell (8/27/24). V7 said she was not in the room when she fell. V7 said she heard V13 (CNA) yelling out. V7 said she went in the room and R1 was laying on the ground, next to her bed, face first. V7 stated, "I think she hit her head on the oxygen concentrator knob. It bled a lot, which added to her anxiety." V7 said R1 just kept begging them to get her up. V7 said R1 was in the hospital a few days and came back with 6 staples and 2 sutures. V7 said R1 also had a half moon shaped skin tear to the left, outer elbow.

On 9/10/24 at 10:58 AM, V13 (CNA) said she worked 8/27/24. V13 said she went into R1's room to get her up for dinner. V13 said R1 likes to lay down after each meal. V13 said R1 sat up, she placed the gait belt on her, had the walker in front of R1, and R1 stood up fine and pivoted to the the right. V13 said the wheelchair was behind her legs and all R1 had to do was sit down in the wheelchair. V13 stated, "Next thing I know she is falling forward." V13 said she was standing behind R1's wheelchair and did not have a hold of the gait belt when R1 went forward. V13 said R1 hit the oxygen concentrator with her head. V13 said R1 never complained of being dizzy. V13 said there was blood everywhere and she yelled for the nurse. V13 said she couldn't remember exactly what R1 was saying, but remembers her repeating, "I'm scared... I fell..." V13 said she knows that she's supposed to have her hands on the gait belt at all times to help control the resident's movement, but she was so surprised by the fall.

On 9/11/24 at 9:04 AM, V14 (Occupational Therapist/Director of Therapy) said a gait belt should be used any time the staff are transferring or ambulating with a resident. V14 said the gait belt should be properly placed and the staff's

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hands should remain on the gait belt at all times, during the transfer. V14 stated, "You never know what could happen. Their knees may buckle or they lose their balance." V14 said the purpose of the gait belt is to assist the resident with balance and if the resident falls or loses their balance, to help guide the resident slowly to a safe landing. V14 said a resident may still end up on the floor, but the staff guiding them down with the gait belt should decrease the severity of any injuries and possibly prevent an injury from occurring.

On 9/11/24 at 12:11 PM, V15 (Nurse Practitioner) said she would expect the facility to safely assist residents with transfers. V15 said she was trained to keep your hands on the gait belt throughout the transfer. V15 said she would expect staff to be using the gait belts properly. V15 said R1's scalp injury was directly related to her fall.

On 9/12/24 at 12:22 PM, V2 (DON - Director of Nursing) said the staff should being using gait belts any time they transfer or ambulate a resident. V2 said there are gait belts in every resident room. V2 said the purpose of the gait belt is to assist the resident with balance and to guide them to a safe place if they lose their balance. V2 stated the proper use of a gait belt should help reduce the risk of injury. V2 said the staff hands should be on the gait belt at all times, during the transfer.

The facility's undated Safety, Body Mechanics, Transfers and Gait Belt Procedures showed, "Purpose: ...4. To educate staff in appropriate transfer methods to ensure compliance with individual resident care plans. If the techniques demonstrated are followed, residents will be more comfortable and safe, risk to staff injury will be greatly reduced and work will be performed more

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efficiently. Procedures: A. Safety: 1. Primary concern is the safety and health of the residents. Residents who are properly transferred by staff help prevent common injuries such as fractures, skin tears, bruises, etc. Resident safety can be accomplished by doing the following: ...e. Use a gait belt to assure firm grip on the resident. f. Get in a position so that you are in control..."
(B)
Statement of Licensure Violations (2 of 3)

300.650a)
300.650d)

Section 300.650 Personnel Policies

a) Each facility shall develop and maintain written personnel policies that are followed in the operation of the facility. These policies shall include, at a minimum, each of the following requirements.

d) The facility shall check the status of all applicants with the Health Care Worker Registry prior to hiring.

These regulations were not met as evidenced by:

The facility failed to check the Health Care Worker Registry prior to hiring facility staff. This has the potential to effect all the residents residing in the facility.

The Facility Data Sheet dated 9/10/24 showed there were 83 residents residing in the facility.

V5's (CNA - Certified Nursing Assistant)'s Health Care Worker Registry dated 9/10/24 showed she was hired 6/25/24.

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V6's (CNA) Health Care Worker Registry dated 9/10/24 showed she was hired 4/9/24.

V10's (CNA) Health Care Worker Registry dated 9/11/24 showed she was hired 2/27/24.

V12's (CNA) Health Care Worker Registry was dated 1/25/22, but the hire date was 6/11/24. V12 did not have a recent Health Care Worker Registry check.

On 9/11/24 at 9:25 AM, V1 (Administrator) said corporate handles all the pre-employment screening for the staff. The surveyor asked the Health Care Worker Registry checks were dated, the day the surveyor requested them (9/10/24). V1 said she did not know but had been cited for this issue before and it should be fixed. V1 said the Healthcare Worker Registry checks should be completed before hire to ensure resident and staff safety. The surveyor asked why V12 (CNA) was hired 6/11/24, but Registry was dated 2 years prior (1/25/22). V1 said maybe V12 worked at the facility before, but a new Registry should have been checked upon re-hiring her.

The facility's Abuse Prevention Policy revised 8/2024 showed, "Our residents have the right to be free form abuse, neglect, misappropriation of resident property, and exploitation. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention ...Policy Interpretation and Implementation: The community's goal is to achieve and maintain an abuse-free environment. As part of the resident

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| S9999 | Continued From page 8<br>abuse prevention program, the administration will provide a safe resident environment and protect the residents from abuse by anyone including, but not limited to: community associates, other residents, consultants, volunteers, associates from other agencies, family members, legal representatives, friends, visitors, or any other individual. Administration will perform the following: Screening: A. It is the policy of this community to screen employees and volunteers prior to working with residents. Screening components include verification of references, certification, and verification of license and criminal background check ..."<br>(C)<br>Statement of Licensure Violations (3 of 3)<br><br>300.650a)<br>300.661<br><br>Section 300.650 Personnel Policies<br><br>a) Each facility shall develop and maintain written personnel policies that are followed in the operation of the facility. These policies shall include, at a minimum, each of the following requirements.<br><br>Section 300.661 Health Care Worker Background Check<br><br>A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code.<br><br>These regulations were not met as evidenced by:<br><br>The facility failed to check the required websites prior to hiring staff. This effects all residents residing in the facility. | S9999 | | |

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The findings include:
The Facility Data Sheet dated 9/10/24 showed there were 83 residents residing in the facility.

V5 (CNA - Certified Nursing Assistant) was hired 6/25/24. V5's Background Screening was dated 9/10/24. (The Background Screening documents provided do not show the required websites are being checked. The required websites include: Illinois Sex Offender, DOC Sex Offender, DOC Inmate Search, DOC Wanted Fugitive, National Sex Offender and HHS OIG.)

V6 (CNA) was hired 4/9/24. V6's Background Screening was dated 9/10/24.

V10 (CNA) hired 2/27/24. V10's Background Screening was dated 9/11/24.

V12 (CNA) was hired 6/11/24. V12's Background Screening was dated 9/11/24.

On 9/11/24 at 9:25 AM, V1 (Administrator) said corporate handles all the pre-employment screening for the staff. The surveyor asked if the Background Checks included the required website checks. V1 said corporate uses the reports provided and she is not involved in the pre-employment screening process. V1 said the facility had been cited for issues with the background checks before and was unsure why it wasn't fixed. V1 said the criminal background screening (website checks) are completed to protect the residents and staff of the facility.

The facility's Abuse Prevention Policy revised 8/2024 showed, "Our residents have the right to be free form abuse, neglect, misappropriation of resident property, and exploitation. This includes,

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| S9999 | Continued From page 10<br>but is not limited to, freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention ...Policy Interpretation and Implementation: The community's goal is to achieve and maintain an abuse-free environment. As part of the resident abuse prevention program, the administration will provide a safe resident environment and protect the residents from abuse by anyone including, but not limited to: community associates, other residents, consultants, volunteers, associates from other agencies, family members, legal representatives, friends, visitors, or any other individual. Administration will perform the following: Screening: A. It is the policy of this community to screen employees and volunteers prior to working with residents. Screening components include verification of references, certification, and verification of license and criminal background check ..."<br>(C) | S9999 | | |