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	IL6003321	A. BUILDING: _____ B. WING _____	08/30/2024

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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 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	S9999		

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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 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:

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.

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These Requirements were not met evidenced by:

Based on interview and record review the Facility failed to ensure a resident was not injured while being pushed in their wheelchair during meal service and failed to seek medical interventions in a timely manner for 1 of 4 residents (R48) reviewed for accidents in the sample of 41. This failure resulted in R48 sustaining a fracture to her left leg while being pushed by staff in her wheelchair and not being sent out to the hospital for two days.

Findings include:

R48's Physician Order Sheet (POS for August 2024) documents a diagnosis of Major Depression disorder, severe with psychotic symptoms, pressure ulcer of left heel, Alzheimer disease, dementia in other disease classified elsewhere, unspecified severity, with other behavioral disturbances, psychotic disorder with delusions due to known physiological condition, and anxiety and bilateral primary osteoarthritis of hip.

R48's Minimum Data Set (MDS) dated 4/4/2024 documents she is severely impaired for cognition for activities of daily living, she has impairments on both sides, she uses a manual wheelchair. She is dependent on staff for eating, oral hygiene, toileting, showering/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene, Rolling from left to right, sit to stand, chair to bed, toilet transfer tub/shower transfer, and she does not walk and is always incontinent of urine and bowel.

R48's Care Plan: "(R48) at risk for falls; due to poor safety awareness. Maintain safe

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environment to room/facility to prevent injuries, well lite environment. Observe resident for any unassisted transfers/ambulation status. Remind to wait for assist and assist residents as needed. B & B (bowel and bladder) before meals/after and as needed. Keep resident clean and dry. Resident to use call lights when assist needed. Report any unsteady balance/gait to Nurse. Report any decline in safety awareness to Nurse (PRN). Use of ¼ side rails times 2, check every two hours and as needed."

R48's Skin/Wound Note dated 5/18/2024 at 1:28 PM, "Note Text: 11 x 6 cm (centimeters) bruise noted to left shin during routine care. Staff reported to this nurse. Leg elevated on pillow and V13, Nurse Practitioner notified and aware. Will monitor until healed."

R48's Incident/Accident report date of incident 5/18/2024, "Staff noticed a 11 x 6 cm light purple bruise to left shin during routine care. Staff reported resident leg was bumped by another resident's wheelchair."

R48's Health Status Note dated 5/19/2024 (Sunday) at 7:49 AM, "Note Text: Resident moaning with pain to left leg, +2 plus edema with warmth to touch. 11 x 6 cm purple bruise to left shin, increased edema and bruising today. Notified NP. Called POA, notified of change at this time and voiced understanding stated she is out of town today and keep her updated."

R48's Health Status Note dated 5/20/2024 at 9:34 AM, Note Text: Received a new order to obtain x-ray of left tib/fib 2 views.

R48's Health Status Note dated 5/20/2024 at 10:45 AM, "Note, Text: (Company) x-ray here

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obtained 2 views of tib/fib at this time."

R48's Health Status Note dated 5/20/2024 at 11:39 AM, "Note Text: NP (V13) here received new order to send resident to ER (emergency room for evaluation and treatment related to left shin x-ray results.)"

R48's Health Status Note dated 5/20/2024 at 11:51 AM, "Note Text: Called POA (Power of Attorney) notified of resident fracture left leg and new order to send to (hospital) for evaluation and treatment. Resident transfer out to ER (emergency room) at this time."

R48's Skin Wound Note Late Entry, created date 5/21/2024 at 10:36 AM, "Staff reported resident sliding down in wheelchair, left lower leg bumped by another resident's wheelchair pedal while in dining room for lunch. Light red/purple abrasion noted. Resident assessed by this nurse, no acute distress noted."

R48's Skin Investigation Report dated 5/18/2024 documents, "On 5/18 resident wheeled to lunch by CNA when wheeled up to table left leg bumped a wheelchair, a light red/purple bruise noted by nurse. On 5/19/2024 bruises are now 11 cm x 6 cm. Resident shows signs and symptoms of pain with transfers, NP notified, order for x-ray leg received on 5/20/2024, after x-ray transferred to ER (emergency room). Findings: Resident was transferred with gait belt of assist of 2. CNA's Interviews with (V12), (V11) (V26) all agree. Resident did walk with restorative staff on 5/18. Verified on camera. Resident returned to facility with order to follow up with ortho. Interventions: Resident was provided care until EMS (emergency medical services) arrived to transport to ER (emergency room) upon return resident

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transfer status was updated. Ortho f/u (follow up) to be made."

R48's Orthopedic Paperwork documents, "R48 was admitted to the hospital on 5/28/2024 and discharged on 5/29/2024, Procedure performed, 'left tibia closed reduction and intramedullary nailing'. This patient is a 92-year-old female with unknown mechanism of injury, presenting with a left tibia fracture. Chief complaint: Left leg pain and swelling."

R48's Skin Injury Investigation Checklist undated with no name documents, "Type of skin injury: 'bruise', staff assigned to resident (V10), certified nursing assistant (CNA) and (V11), CNA. How was skin injury found? During routine care. Resident's activity at the time of the skin injury; sitting in wheelchair. What the resident said happened: Unable to voice. Does the resident self-ambulate or self-propel wheelchair around the facility; 'No'. Was there a prior injury to this area recently? 'No'"

R48's Initial Incident Report dated 5/20/2024, "Staff reported that (R48) resident had a bruise noted to lower left leg. Nurse V12, Licensed Practical Nurse (LPN)) reported to (V13) Nurse Practitioner that bruise had gotten larger, so NP ordered x-ray of lower leg. The x-ray report came back and shows a fracture. (R48) was sent to (hospital) for evaluation and treatment. (R48) later that same day returned to this facility with an order to follow up with an orthopedic doctor."

R48's Final Incident Report, "Resident (R48) was admitted to (Facility), March 21, 2019 and has been a long term care resident since then. Her admitting diagnosis for care was dementia. On 5/18/2024 the assigned staff to (R48), (V12,

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LPN), (V10, CNA), (V11, CNA) and (V10, CNA) reported to (V12, LPN) after meal that (R48) was sliding down in her wheelchair at meal so they repositioned her while in the dining room. While repositioning her (R48) (bumped the shin of her left leg on another resident's wheelchair pedal). Nurse assessed resident at the time. Noted a small, light bruise that measured approximately 11 cm x 6 cm and small abrasion. Nurse monitored the bruise and filled out incident report as per policy. (State), NP, Administrator, DON and all notified in a timely manner. On 5/19/2024 staff noted bruise had grown in size and notified nurse (V12). V12 informed (V13, NP) of bruise as well as POA."

R48's Accident/Incident Report reported to State on 5/20/2024 documents, "Staff reported that (R48) had a bruise noted to lower left leg. Nurse (V12) reported to (V13) that bruise had gotten larger, so NP ordered an x-ray of left lower leg. The x-ray report came back and shows a fracture. (R48) was then sent to the hospital for evaluation and treatment, (R48) later that same day returned to this facility with an order for follow up with an orthopedic doctor. (R48) was admitted to (Facility) on 3/21/2019 and has been a long-term care resident since then. Her admitting diagnosis for care was dementia. On 5/18/2024 the staff assigned to (R48) were (V12, LPN), (V10, CNA), (V11, CNA), and (V14, CNA), who reported to (V12) that (R48) was sliding down in her wheelchair at meal, so they repositioned her while in dining room. While repositioning her (R48) bumped her shin of her left leg on another resident's wheelchair pedal. Nurse assessed leg at that time. Noted a small, light purple bruise that measured approximately 11 cm x 6 cm and small abrasion. Nurse monitored the bruise and filled out incident report as per policy".

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R48's Radiology Report with a report date of 5/20/2024 at 10:55 AM, Findings: Proximal tibia/fibula fractures with mild displacement. Mild soft tissue swelling. Conclusion: Acute appearing proximal tibia/fibula fractures as noted.

On 8/29/2024 at 10:41 AM, V12, Licensed Practical Nurse stated, "(V11) and (V10) came and got me and told me they had found a bruise on (R48's) leg while they were doing care. I went and looked at it and I did an incident report. I was watching the bruise and they did an investigation on her. (R48) did not walk and was unable to propel herself in the wheelchair. At the time of the incident (R48) was in a manual wheelchair with foot pedals. We think that at mealtime they accidentally hit her foot with the other resident. I do not know who the other resident was, that was while they were pushing the other resident under the table, and then they collided. (R48's) bruise was progressively getting worse and I called the Nurse Practitioner and she had me get an x-ray, and when the x-ray came back we learned she had fractured her leg. I was in shock and blown away because I did not expect (R48's) foot to be fractured from colliding with another resident."

On 8/29/2024 at 2:02 PM, V11, Certified Nursing Assistant stated, "Me and (V10, CNA) were taking care of (R48). We got her up and took her to breakfast. (R48) was in a regular wheelchair with foot pedals. She was not able to propel herself. After breakfast the nursing aid, I do not know her name, she was agency, told me that she had bumped (R48's) leg at the dining room table that morning. When we took (R48) back to her room and laid her down, she winced and even though she could not talk she was grimacing, and you could tell her leg hurt her and she had a

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red/purple bruise. I went and got the nurse (V12) and had her look at it. (V12) was monitoring it and contacted the doctor and got an x-ray and later we found out she had a fracture. We were all in shock."

On 8/30/2024 at 9:33 AM, V26, Registered Nurse (RN) stated, "I was working the Medicaid Hall that day. When I saw the bruise on R48's leg for the first time I was not sure what or why it had happened. She could not propel herself in the chair or move her legs and she could not tell you what happened. She could not talk. She had a history of sliding down in her chair that is why she is now in a geriatric chair. I heard something about a staff member bumping her leg but I am not sure who the staff member was. I remember sending a message to the Nurse Practitioner. We were all in shock when we learned her leg was fractured."

On 8/30/2024 at 11:03 AM, "V10, Certified Nursing Assistant (CNA) stated, "I remember taking (R48) back to her room after lunch and when laying her down we, (me and (V11, CNA) noticed a bruise on her leg. We immediately notified the nurse (V12, LPN). Before laying her down she had no prior pain or symptoms. After laying her down she would grimace when we touched the bruise. She cannot talk or tell you what had happened. No staff told me that there was any accident and or injury to (R48). I was working the night shift and I was very surprised to learn that she had a fracture. I am no longer employed at the facility."

On 8/30/2024 at 2:40 PM, V13, Nurse Practitioner stated, "The documentation on this case was poor and what we know is that (R48) had a fracture, and we were not sure how she got that

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fracture. There was a late entry and I have many issues with that because staff should have documented immediately if she was hit by accident or with other residents and at the end, we can only go by what is documented. It is hard to say and an unusual case. Without names and dates I just have issues. I would not expect a resident to be injured while being pushed in a wheelchair."

The Facility Abuse Policy updated 9/26/2023 documents, "Establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment. Timely and thorough investigations of all reports of allegations of abuse. The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur. The Director and/or Assistant Director of nursing is responsible for reviewing the incident report and reporting any findings to the facility administrator. If the resident complaints of physical injuries or physical injuries are noted, the resident's physician and representative will be contacted for further instructions."

The Accident/Incident Policy revised 12/2023 documents, "All accidents or incidents that result in an injury or illness must be reported to the Administration, DON (Director of Nursing), or ADON (Assistant Director of Nursing). The DON will make an initial report of the incident and report it to (State) through facility Reported Incdient. The following data, as it may apply, must be included in the Accident/Incident Report form: Date and time accident/ incident occurred circumstances surrounding accident/incident. Where the incident/accident occurred. Name (s) of any witness (es) and his/her account of the

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accident or incident."
(A)

Statement of Licensure Violations (2 of 2)

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 evidence by:

Based on interview and record review, the facility failed to obtain/ conduct pre-employment screening and obtain results of fingerprint checks to determine if employees had a prior criminal history which would disqualify them for employment. This had the potential to affect all 98 residents living in the facility.

Findings include:

Facility Abuse Policy dated 9/26/2023 states "This facility will not knowingly employ any individual convicted of resident abuse or misappropriation of resident property. The facility will not knowingly employ any direct care staff convicted of any of the crimes listed in the IL Healthcare Background Check Act (unless wavered under the provision of the Act), or with findings of abuse listed on the IL Nurse Aide Registry. Prior to a new employee starting a work schedule this facility will: file a completed fingerprinting based UCIA authorization and Disclosure for Criminal History Records Information check form 10 working days after signature; check appropriate websites to ensure that potential employees name is not

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listed, set up an appointment for the Livescan fingerprinting for all staff. The facility policy and procedures for conducting a Healthcare Worker Background Check will be followed.

On 8/29/2024 seven employee files were reviewed for pre-employment screening. The following was documented:

V16, Certified Nursing Assistant, CNA, was hired on 7/31/2024. The facility failed to ensure a criminal background check was completed prior to employee providing care to residents.

V17, Certified Nursing Assistant, CNA, was hired on 8/7/2024. The facility failed to ensure a criminal background check was completed prior to employee providing care to residents.

V18, Certified Nursing Assistant, CNA, was hired on 7/26/2024. The facility failed to ensure a criminal background check was completed prior to employee providing care to residents.

V19, Certified Nursing Assistant, CNA, was hired on 8/2/2024. The facility failed to ensure a criminal background check was completed prior to employee providing care to residents.

V20, Dietary Staff, was hired on 7/31/2024. The facility failed to ensure a criminal background check was completed prior to employee providing care to residents.

V21, Certified Nursing Assistant, CNA, was hired on 7/18/2024. The facility failed to ensure a criminal background check was completed prior to employee providing care to residents.

V22, Certified Nursing Assistant, CNA, was hired

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S9999	Continued From page 12 on 7/23/2024. The facility failed to ensure a criminal background check was completed prior to employee providing care to residents. On 8/29/2024 at 8:30AM, V23 Business Office Manager, stated "I check that the employee is eligible before they start. The employee is hired, starts, and I run the background check the day they start on the floor. This is how I was taught." The Resident Census CMS 671, dated 8/27/2024 documents that the facility has 99 residents living in the facility. (C)	S9999		