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S 000	Initial Comments Facility Reported Incident of 10/09/24/IL179462 10/10/24/IL179466	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 3) 300.610a) 300.1210a) 300.1210b) 300.3210t) 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)

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.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These regulations were not met as evidenced by:

Based on interview and record review the facility failed to protect a resident's (R2) right to be free from sexual abuse by another resident (R1). This failure resulted in R2, who is cognitively impaired, as a reasonable person that would not expect to be sexually abused in their own home or health care facility, causing them to feel fear, anxiety, and anger.The facility also failed to protect a resident's (R4) right to be free from physical

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abuse by another resident (R3) and protect a resident's (R6) right to be free from physical abuse by another resident (R4). These failures affected 5 (R1, R2, R3, R4, and R6) of 5 residents reviewed for abuse in a sample list of 14.

Findings include:

The facility's Abuse Prevention Program dated 11/28/16 documents the facility's residents have the right to be free from abuse and dementia management is listed as one of the measures implemented to prevent abuse. This policy documents abuse is the willful infliction, a deliberate act, of injury, unreasonable confinement, intimidation, or punishment that results in physical harm, pain or mental anguish. This policy documents non-consensual sexual contact of any type is sexual abuse.

1.) The facility's Final Report to IDPH (Illinois Department of Public Health) documents the following: On 10/9/24 at 6:30 PM V1 Administrator in Training was notified of an altercation between R1 and R2, and during the investigation it was identified that the altercation was actually inappropriate touching. Staff interviews determined R1 was sitting in the leisure room, R2 wandered into the room and sat beside R1, and R1 placed his hand on R2's right inner thigh and perineal area. R1 and R2 were immediately separated.

V19 Unit Aide Witness Report dated 10/9/24 at 6:35 PM documents V19 witnessed R1's hand on R2's inner right thigh and R1 aggressively/firmly moved his fingers up and down R2's vaginal area on the outside of R2's clothing. V14 Certified Nursing Assistant (CNA) written statement dated

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10/9/24 documents V19 witnessed R1 grab and rub R2's vaginal area.

R1's Minimum Data Set (MDS) dated 9/20/24 documents R1 has severe cognitive impairment and has daily verbal, physical, and other behaviors during the review period. R1's Care Plan with revised date 10/11/24 documents R1 has sexually inappropriate behaviors towards staff and R1 was sexually inappropriate to a female resident.

R2's MDS dated dated 8/5/24 documents R2 has a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment.

On 10/16/24 at 10:31 AM V14 CNA stated R2 sat next to R1 in the leisure room and V14 witnessed R2 stroke R1's vaginal area on the outside of R2's clothing. V14 stated R2 did not seem aware of R1's actions.

On 10/16/24 at 10:55 AM V19 Unit Aide stated V19 was in the leisure room on the dementia unit with residents watching a movie. V19 stated R2 was sitting next to R1 and R1 firmly put his hand onto R2's inner thigh and moved his fingers aggressively along R2's vaginal area on the outside of R2's clothing. V19 stated R2 had a blank look on her face, R2 was confused, and R2 did not seem aware of R1's actions. V19 stated V19 immediately separated R1 from R2, and the incident was reported to V1 Administrator in Training. V19 stated R2 has previously made inappropriate sexual comments towards staff regarding their breasts and butt.

On 10/16/24 between 11:20 AM and 11:22 AM V3 Licensed Practical Nurse and V12 Social Services Director/Dementia Unit Director stated

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R2 is confused, R2 does not recognize her family, and R2 does not have the cognitive ability to consent to sexual touching.

On 10/26/24 at 12:58 PM V21 (R2's Family) was asked how R2 would have responded to the incident with R1 if R2 did not have cognitive impairment. V21 stated R2 would not like being touched by R1, and R2 would have been afraid of R1 since R2 does not know R1.

On 10/16/24 at 1:27 PM V1 Administrator in Training stated the BIMS score is used to determine the resident's ability to consent to sexual activity, and a BIMS score of 13-15 indicates the resident is cognitively intact and able to consent. V1 stated the family and physician are also involved and the nurse educates the residents on safe sex practices.

2.) The facility's Final Report to IDPH documents on 2/28/24 at 3:45 PM R7 walked into R3 and R3 pushed R7 causing R7 to fall. The facility's Final Report to IDPH documents the following: On 10/13/2024 at 1:45 PM V1 Administrator in Training was notified of an altercation between R3 and R4. Staff heard scuffling in R4's room and witnessed R3 had R4 by the arm and would not let go. R3 is "very territorial (per usual)". This most likely occurred due to a recent room change that caused R3 and R4 to share a bathroom. R4 was moved to a different room.

V7 CNA written statement dated 10/13/24 documents at approximately 1:45 PM V7 heard a loud noise, went to R4's room, and R4 opened the door trying to get away from R3 who had hold of R4's arm. This statement documents R3 and R4 were arguing, R4 got his arm free from R3, and then R3 swung at R4.

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R3's MDS dated 9/20/24 documents R3 has severe cognitive impairment, hallucinations, and daily verbal, physical, and other behaviors during the review period. R3 requires supervision or touching assistance for transfers and walking.

R4's MDS dated 9/27/24 documents R4 has a severe cognitive impairment and requires supervision or touching assistance for walking.

On 10/16/24 at 1:27 PM V1 stated R3 has a history of physical aggression towards other residents, and on 2/28/24 R7 walked into R3 and R3 pushed R7 down.

On 10/16/24 at 1:56 PM V7 CNA stated V7 heard a noise "like someone fell", V7 went to R4's room and witnessed R4 open the door trying to leave the room. V7 stated R3 had hold of the underside of R4's forearm and R4 was trying to lift his arm to get away from R3. V7 stated R3 and R4 were upset with each other and R3 attempted to swing and hit R4, but V7 was able to intervene and prevent additional contact. V7 stated V7 believed R3 used the bathroom, which adjoined with R4's room, and R3 entered into R4's room by mistake. V7 stated R4 is fine until someone messes with R4 or R4's belongings.

3.) The facility's IDPH Notification Form dated 10/15/24 documents an allegation of a resident to resident physical altercation between R4 and R6 that occurred on 10/15/24 at 5:15 PM. V15 Unit Aide's undated written statement documents on 10/15/24 between 5:10 PM and 5:20 PM R4 was eating and R6 was rubbing the table, R4 thought R6 was reaching for R4's food and smacked R6's hand against the table with R4's closed fist. This statement documents R4 was fully aware of R4's

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actions and R4 stated R4 acted because R4 thought R6 was trying to grab R4's food.

R6's MDS dated 9/9/24 documents R6 has short term and long term memory impairment, transfers and walks with supervision or touching assistance, and has daily verbal, physical, and other behaviors during the review period. R6's Care Plan dated 6/6/23 documents R6 has behaviors that others may find disruptive and socially inappropriate which may cause others to seek reprisal against R6. This care plan documents R6 had altercations with other residents and goes into other resident rooms, and includes an intervention to intervene as needed as soon as R6's behavior is noted to ensure residents' safety.

On 10/16/24 at 2:50 PM V15 Unit Aide stated last evening around 5:20 PM R6 was finished eating and R6 was rubbing the tables, which she likes to do. V15 stated R4 thought R6 was reaching for R4's food and R4 took his closed fist and smacked the back of R6's hand. V15 stated R4 acted intentionally, R4 later apologized and said that R4 acted because R4 thought R6 was going to take R4's food. V15 stated we try to keep R6 away from R4, because R6 likes to grab other residents' food.
(B)
Statement of Licensure Violations (2 of 3)

300.610a)
300.1210a)
300.1210b)
300.1210d)6)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and

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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 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

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care and personal care shall be provided to each resident to meet the total nursing and personal 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 implement safety measures, adequate supervision and toileting assistance to prevent falls (R2, R5); and failed to develop and implement fall interventions and thoroughly complete fall investigations (R1, R2, R5). These failures affected 3 (R1, R2, and R5) of 3 residents reviewed for falls in the sample list of 14. These failures resulted in R2 and R5 sustaining falls with lacerations that required emergency room treatment of medical glue closure.

Findings include:

The facility's Fall Prevention policy dated 11/10/18 documents all staff must observe residents for safety and if residents who are high risk for falls are observed up assistance must be summoned/provided. This policy documents to conduct a fall huddle after the fall with the staff on duty to identify details of the event and

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appropriate interventions, and the nurse will document the circumstances of the fall and the new interventions. Falls will be reviewed during the morning Quality Assurance meetings and the resident's care plan will be updated with new interventions. This policy lists properly fitting clothing, frequent checks while in bed, and frequent toileting schedule as some of the fall prevention interventions.

1.) The facility's Final Report to IDPH (Illinois Department of Public Health) documents on 9/19/24 at 3:00 PM R2 was witnessed to trip on a mound of dirt on the grass patio area causing R2 to fall face first on the concrete. This report documents R2's fall likely occurred due to R2's Dementia diagnosis and the mounds of dirt caused by moles; and the post fall intervention is that the patio area will be frequently monitored to ensure mole mounds are taken care of right away. V16 Activity Aide Witness Statement dated 9/19/24 documents residents were outside on patio area, R2 walked off of the concrete area onto grass and tripped on a mound of dirt causing R2 to fall face first onto the concrete. R2's Assess Intervene and Monitor for Wellness form dated 9/19/24 at 3:58 PM documents R2 fell outside on the patio and R2 had skin tears to the left elbow and upper arm, an abrasion to the left elbow, and a facial laceration. R2's Emergency Department Notes dated 9/19/24 document R2 presented due to a fall while outside on the facility's patio and R2 had a laceration to the left cheek, an abrasion to left shoulder, and skin tear to the left elbow. R2's left cheek laceration required medical glue closure.

R2's Minimum Data Set (MDS) dated 8/5/24 documents R2 has severe cognitive impairment and requires supervision or touching assistance

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for transfers and walking. R2's Care Plan dated 9/26/24 documents R2 is at risk for falls related to cognitive impairment, R2 does not understand limits and R2 has poor safety awareness. This care plan includes an intervention dated 9/19/24 to level out dirt mounds on the patio and an intervention dated 9/26/24 to ensure R2 is wearing pants that fit properly.

R2's Nursing Note dated 9/26/2024 at 3:22 PM documents R2 fell in another resident room after slipping on her pant legs that were too long, and R2 sustained a cut above her right eye from the clip on the call light cord. R2's Interdisciplinary Note dated 9/26/24 documents the root cause of the fall as R2's pants were too long and the new fall intervention was to ensure R2 wears pants that fit properly. There is no documentation that staff were interviewed regarding this fall to determine who found R2, when R2 was last observed prior to the fall, and what R2 was doing at that time.

On 10/16/24 at 9:27 AM V16 Activity Aide stated V16 witnessed R2's fall on the patio, R2 was walking outside in the patio area, and the mole mounds "are horrid out there".V16 stated we are constantly stomping them down and V16 told R2 "to be careful." V16 stated R2 then tripped over a mole mound causing R2 to fall and hit R2's head on the pavement, which broke R2's glasses and caused a cut by R2's eye. V16 stated R2 was not wearing shoes at the time, since R2 is not use to wearing shoes. V2 stated all of the staff were aware of the mole mounds prior to the fall and we would try to stomp them down. V16 stated V16 doesn't believe the facility had a maintenance staff at that time.

On 10/16/24 at 12:39 PM V3 Licensed Practical

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Nurse (LPN) stated V3 was R2's nurse on 9/26/25 and R2's fall was unwitnessed. V3 stated it was believed that R2 slipped on her pants that were too long and hung underneath R2's feet. V3 stated R2 cut her forehead on the call light cord clip during the fall. On 10/16/24 at 12:40 PM V5 Certified Nursing Assistant (CNA) stated R2 was found on the floor of another resident's room and R2 was wearing pants that were too long, which were removed from R2's closet after the fall.

On 10/16/24 at 1:05 PM V1 Administrator in Training stated V1 would have set traps to address the mole issue if V1 had been notified, but no one had reported the mole issue to V1 until after V1 was investigating R2's fall on 9/19/24. On 10/17/24 at 9:00 AM V1 stated V1 had no documentation of staff interviews for R2's fall on 9/26/24. V1 stated V1 went to the unit for R2's fall and R2 was wearing an outfit that didn't belong to R2 as the pants were too long and the staff had tried rolling the pantlegs up. V1 stated R2 had slipped on her pants and V5 and V6 were the CNAs working R2's unit at the time. V1 stated V1 has told the staff that V1 needs written statements any time there is a resident fall, but the staff aren't always good about doing that. V1 stated the staff should document and describe any environmental factors and the resident's footwear at the time of the fall. V1 confirmed there should be documentation of information prior to a resident fall, such as when the resident was last toileted, when the resident was last checked on and the resident's activity at that time.

2.) On 10/16/24 at 8:00 AM R5 had facial bruising and swelling around he left eye and forehead. Attempts were made to interview R5, but R5's speech was unclear and R5 was unable to appropriately answer questions. At 8:07 AM R5

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was walking in the hallway with a wheeled walker and assistance from V6 CNA.

The facility's Final Report to IDPH documents R5 fell on 10/10/24 at 3:42 PM and was found sitting on the floor of the room next to R5's after leaving the bathroom. This report documents R5 went into the wrong room without R5's walker and had a laceration above R5's left eye, a bump on R5's forehead, and a skin tear to the left elbow. The facility documents the conclusion of R5's fall as R5 is known to get up without R5's walker at times and therapy evaluation and treatment as the post fall intervention. The facility's investigative file for R5's fall provided by V1 on 10/16/24, only included one written statement from staff, V8 CNA. V8's written statement dated 10/10/24 documents V8 was in the television room to prevent resident behaviors, V8 heard R5 yell and found R5 lying on the floor with blood on R5's face. There are no other documented interviews as part of R5's fall investigation to determine when R5 was last toileted or R5's activity when last observed prior to the fall.

R5's Emergency Department Notes dated 10/10/24 document R5 presented for an unwitnessed fall with bleeding and contusion of the left forehead. R5 had a puncture wound near the hairline that measured four millimeters and a one centimeter laceration near the left eye brow that both required medical glue closure.

R5's MDS dated 9/16/24 documents R5 has severe cognitive impairment and requires partial/moderate staff assistance for toileting hygiene and toileting transfers. Walking assistance is documented as not attempted for this assessment. R5's Care Plan with revised date 3/13/24 documents R5 performs Activities of

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Daily Living with setup help and verbal cues, and R5 walks independently with a walker and cues for locations as needed. This care plan documents an intervention dated 7/5/23 that R5 is independent with toileting with setup assistance, and has not been updated to reflect R5's toileting assistance as noted on R5's 9/16/24 MDS. R5's Care Plan with revised date 10/11/24 documents an intervention dated 10/10/24 for therapy to evaluate and treat.

The facility's Daily Assignment Sheet dated 10/10/24 documents V8 as the only CNA working on the unit between 3:00 PM and 4:00 PM.

On 10/16/24 at 8:20 AM V8 stated V8 was the only staff member on the unit when R5 had an unwitnessed fall on 10/10/24. V8 stated V8 was with other residents preventing behaviors when V8 heard R5 yell. V8 found R5 lying on the floor of R5's adjoining room, R5 was bleeding from R5's eyebrow, and R5 did not have R5's wheeled walker with R5. V8 stated V8 was aware that R5 was in the bathroom, but R5 would take herself to the bathroom and was independent with walking and using the wheeled walker. At 12:12 PM V8 stated on 10/10/24 at approximately 1:00 PM V8 toileted R5 and assisted R5 to bed, and R5's wheeled walker was within reach at that time. V8 stated V8 had passed by R5's room a few times prior to the fall and R5 was in bed asleep.

On 10/16/24 at 9:42 AM V3 LPN stated V3 was R5's nurse and V8 was R5's CNA on 10/10/24. V3 stated R5 was in R5's bedroom and R5 has a history of getting up and walking by herself without her walker. V3 stated R5 left her walker outside of the bathroom door in R5's room, but R5 must have gotten confused and went into the adjoining room where R5 fell. V3 stated R5 had a

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cut and bump above her eye and was sent to the emergency room where medical glue was applied to close the cut. V3 confirmed V3 was not on R5's unit when R5 fell. V3 stated one CNA is not enough for R5's unit since the residents are "always on the go" and need assistance.

On 10/16/24 at 11:44 AM V2 Director of Nursing stated V2 does not have any additional fall investigation documentation besides what is documented in the progress notes. At 4:44 PM V2 stated R5 usually gets out of bed, grabs R5's walker, and goes to the bathroom. V2 stated R5 is incontinent and the staff should prompt and assist R5 to toilet at least every two hours. V2 stated it is standard to have two CNAs assigned to the dementia unit and there are times recently that staff only worked partial shifts. V2 reviewed the 10/10/24 Daily Assignment Sheet and confirmed V8 was the only CNA on the unit between 3:00 PM and 4:00 PM. V2 stated V11 the Former Dementia Unit Director should have been on the unit at that time, but V11 had left the facility without notifying anyone. V2 stated "We determined staffing as a factor for this fall, just didn't document that."

On 10/17/24 at 9:00 AM V1 stated V1 had no other written statements for R5's 10/10/24 fall. V1 confirmed R5's fall investigation was not thorough and does not document staff statements were obtained from other staff that were assigned to R5's unit when R5 fell, and there was no documentation to determine when R5 was last toileted or observed prior to R5's fall.

3.) R1's Diagnoses Sheet updated October 11, 2024 documents the following:
Diffuse Traumatic Brain Injury With Loss of Consciousness Of Unspecified Duration,

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Subsequent Encounter, Mild Cognitive Impairment Uncertain or Unknown Etiology, Anxiety Disorder Unspecified, Unspecified Osteoarthritis Unspecified Site, Other Intervertebral Disc Degeneration Lumbar Region, Non-Surgical Orthopedic/Musculoskeletal, Essential (Primary)Hypertension, Long Term (Current) Use of Anticoagulatants, and Personal History of Pulmonary Embolism.

R1's Physician Order Sheet dated 10/17/24 documents: Apixaban (anticoagulant/blood thinner) Oral Tablet 2.5 milligrams, give one tablet by mouth two times a day.

R1's Minimum Data Set dated 9/20/24 documents R1 has a Brief Interview of Mental Status score of six out of a possible 15, indicating severe cognitive impairment. The same MDS documents R1 has had two or more falls, has no range of motion limitation of upper or lower extremities and is incontinent of bowel and bladder.

R1's Fall Risk Evaluation dated 9/19/24 documents R1's fall risk score as 19. The same risk evaluation documents the following: "Assess the resident status below. If the total score is 10 or greater, the resident should be considered HIGH. RISK for potential falls. Prevention protocol should be initiated immediately and documented on the care plan."

The facility provided a fall log on 10/16/24, that documented R1 had falls 9/5/24, 9/12/24, 9/19/24, and 10/10/24. V1, Administrator confirmed an additional fall 10/15/24 had occurred that is not documented on the fall log.

R1's Care Plan dated 10/10/24 documents the

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following: "The resident review shows risk for falls. Risk Factors include: Behavior- impulsive without regard for safety, Deconditioning: 9.5.24-rolled out of bed, 9.12.24 Leisure room loss balance, 9.19.24 dining room." The same Care Plan documents the following fall interventions:
· 9.5.24-scoop mattress
Date Initiated: 09/05/2024
· 9.12.24-medication review
Date Initiated: 09/13/2024
· 9.19.24-placed on 15 min checks for 24 hrs (hours)
Date Initiated: 09/20/2024"

R1's same Care Plan dated 10/10/24 documents: "Resident is usually able to to perform ADLs (activities of daily living) with max (maximum) hands on assist. Intervention: TOILET USE: The resident is totally dependent on two staff for toilet use." This care plan documents: "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." R1's same care plan does not document falls and fall interventions that occurred 10/10/24, 10/12/24 and 10/15/24.

On 10/17/24 at 12:55 pm V2, Director of Nursing (DON) reviewed R1's fall investigations for 9/5/24, 9/12/24, 9/19/24, 10/10/24, 10/12/24 and 10/15/24. V2 confirmed R1 had falls on 10/10/24, 10/12/24 and 10/15/24 that did not include intervention related to R1's falls 10/10/24, 10/12/24 and 10/15/24. V2 stated "(V24), Registered Nurse was hired to start next week as the designated Care Plan Coordinator, until then, all nurses are responsible for updating the care plan. V2 also confirmed R1s fall intervention documented for R1's 9/19/24 fall was to

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complete 15 minutes checks. V2 stated the 15 minutes checks were not completed by the Certified Nursing Assistants as they were supposed to be for that fall. V2 confirmed there were no interviews documented for R1's falls on 9/5/24, 9/19/24 and 10/10/24. V2 stated "All investigations should include witness statements, if the fall was witnessed or not. It is necessary in order to determine what caused the fall and if there are any injuries that need continued assessments. I can't know what type of intervention to put in place unless the fall is thoroughly investigated."

R1's A.I.M. (Assess Intervene Monitor) For Wellness-Event Record dated 10/15/2024 at 11:55 pm documents the following: "Note Text: Event Details: (R1) appears to have experienced an alleged Intentional Change in Plane; Witnessed w/o (without) head involvement (confirmed in interviews head involvement could not be determined, see below). Event was first noted on 10/15/2024, 11:55 PM Evaluation of the resident and event occurred on or about 10/15/2024 11:55 PM. Just prior to/at the time of the event (R1) appears to have been lying in bed. (R1's) account of the event is resident has hx (history) of Dementia and unable to account incident. Witness to the event includes: (V20, Certified Nursing Assistant/CNA) see nurses note 10/15 23:55 (11:55 pm). Location of the event is: residents (R1) room. Description of the environment at the time of the event includes: clean, dry, well lit. Staff's immediate response is noted as the staff (V20, CNA)(attempted) lower resident to floor for safety. Body assessment completed. This type of event is believed to not have occurred previously (documented falls as noted above). See also A.I.M. For Wellness-Event Record for additional details. A-

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Assessment/Evaluation: BP (Blood Pressure) 155/89 -10/15/2024 23:58 Position: Lying l/arm P (Pulse) 97 - 10/15/2024 23:55 Pulse Type:Regular R (respirations) 18.0 - 10/14/2024 11:27 T (temp) 98.0- 10/15/2024 23:58 Route: Forehead (non-contact) BS (Blood Sugar) 174.0 - 10/15/2024 12:31 O2 (oxygen saturation) 96 % - 10/15/2024 23:57 Method: Room Air A Neurological Checklist does not appear to be warranted (confirmed in interview neurological assessment should have been conducted as it is unknown if R1 hit his head) at this time. Review of (R1's) medication reveals: The resident does not have any noted medication changes in the last week. The resident is not on Warafin. The resident does not take a direct thrombin inhibitor or platelet inhibitor (R1 does take Apixaban as noted above on POS). Resident is not on Hypoglycemic Medication/Insulin. Resident does not take Digoxin. Resident does receive antidepressant medication .The resident does not appear to have had any changes in psychotropic medication in the last 30 days. No changes observed in functional status within the last 3 days. Enabler in use include: No Change in cognition/decision making noted within last 3 days. Sensory enabler in use include: N/A No changes noted in behavior within the last 3 days. No change in lifestyle/routine noted the last 3 days includes. No changes noted in respiratory status in last 3 days. No changes in cardiovascular status noted within the last 3 days. No changes observed/noted within the last 3 days. GU (genitourinary) status not clinically applicable to the change in condition being reported. No changes in GU symptoms noted within the last 3 days."

On 10/17/24 at 10:33 am V20, Certified Nursing Assistant (CNA) stated she worked 10/15/24

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when R1 fell from bed. V20, CNA stated she raised R1's bed approximately "three feet or a little more" to change R1's incontinence brief in bed. V20 stated V26, CNA was also working the same hall. They split up to get rounds done for all the residents. V26, CNA was in another resident's room, while V20, was providing R1's care alone. V20 stated "I (V20) did not know R1 required two people to change him. Often, we do have two CNA's to provide his (R1's) care. It is much easier and safer." V20 also stated R1 was laying on his side facing away from V20 as V20 provided posterior incontinence care. V20 asked R1 to stop rolling. R1 kept leaning and started to roll out of the bed. V20 grabbed his shirt and pants as best she could and tried to lower him to the floor, from the opposite side of the bed. V20 stated "I did not actually see him land on the floor because I was on the opposite side of the bed. I was not able to hold on to him all the way down." V20 stated "I did not hear a loud thump like he hit his head or anything. He was not complaining of anything but back pain. The nurse came in and so did (V26). We helped him up and got him back in bed. That is all he wanted to do."

On 10/17/24 at 12:55 pm, during the same review of R1's fall investigations V2, DON/Director of Nursing, in review of R1's 10/15/24 fall investigation and care plan (noted below), V2, DON stated " (V20) CNA should have had the second (V26) CNA assist to meet R1's toileting needs in bed. He is a slippery one. He can also be inappropriate grabbing the CNAs during care. A second CNA could have prevented the fall or most likely would have."

On 10/17/24 at 1:45 pm V4, Licensed Practical Nurse stated V4 was the nurse when R1 fell 10/15/24. V4 said she understood R1 had not hit

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his head when she had done a full physical assessment while R1 was on the floor. (R1) was trying to get up on his own from the floor and responded to me appropriately when I asked his to grip my fingers and move his legs. I completed his assessment in bed because he was getting up on his own. He had previous back pain I had given him Tylenol for within a half hour. When I assessed him for pain he only had the pain he always has. I took her at her word, that (V20) lowered him (R1) to the ground from his bed while (V20) was changing him. If he was supposed to have two people I would think the CNA's already new that. Usually when I have worked the CNA's work together." V4 also stated R1 does turn on his call light. Sometimes she has seen him turn his call light on and yells help me, over and over until staff goes in to check on R1.

On 10/17/24 at 11:55 am, V23, Housekeeper, was in R1's room cleaning. R1 was in the dining room. R1 had a scooped mattress on his low bed. R1's call light cord extended from the wall outlet to R1's bed. A red button to depress for activation was at the end of cord. The call light cord, button end was attached by a clip to R1's bed. The call light button was pushed, and did not activate the light outside his room or activate sound to direct staff to R1's room. V23, verified R1's call light was not functioning properly and stated she will get him a new one.

On 10/17/24 at 12:00 pm R1 was seated in a chair in the dining room eating. R1 stated he does not remember anything about any falls, except "The floor was cold when he fell out of bed." When asked how long he was on the floor he said he would have to guess, maybe 15 minutes. R1 stated "I try to always use the call light, but sometimes forgets."

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S9999	Continued From page 21 On 10/17/24 at 12:05 pm V2, Director of Nursing stated "All residents are to have a call light that works, especially resident with fall history." (B) Statement of Licensure Violations (3 of 3) 300.610a) 300.615e) 300.615f) 300.615g) 300.615i) 300.615j) 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 300.615 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	S9999		

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seeking admission to the facility, unless a background 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.

g) If the results of the background check are inconclusive, the facility shall initiate a fingerprint-based check, unless the fingerprint check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the resident's health or lack of potential risk, such as the existence of a severe, debilitating physical, medical, or mental condition that nullifies any potential risk presented by the resident. (Section 2-201.5(b) of the Act) The facility shall arrange for a fingerprint-based background check or request a waiver from the Department within 5 days after receiving inconclusive results of a name-based background check. The fingerprint-based background check shall be conducted within 25 days after receiving the inconclusive results of the name-based check.

i) The facility shall provide for or arrange for any required fingerprint-based checks to be taken on the premises of the facility. If a fingerprint-based check is required, the facility shall arrange for it to be conducted in a manner

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that is respectful of the resident's dignity and that minimizes any emotional or physical hardship to the resident. (Section 2-201.5(b) of the Act) If a facility is unable to conduct a fingerprint-based background check in compliance with this Section, then it shall provide conclusive evidence of the resident's immobility or risk nullification of the waiver issued pursuant to Section 2-201.5(b) of the Act.

j) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based background check are pending; while the results of a request for waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending.

These regulations were not met as evidenced by:

Based on observation, interview and record review the facility failed to complete resident criminal history background checks for one (R4) of five residents reviewed for abuse in the sample list of 14. This failure has the potential to affect 12 residents (R1, R2, R3, R5, R6, R8, R9, R10, R11, R12, R13, R14) who reside with R4 on the locked dementia unit.

Findings include:

R4's Minimum Data Set dated 9/27/24 documents R4 has severe cognitive impairment and requires supervision or touching assistance for walking. R4's ongoing Census documents R4 admitted to the facility on 9/17/24.

R4's Criminal History Response dated 2/13/24

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S9999	Continued From page 24	S9999		

documents R4 has a conviction history of aggravated assault and battery and R4's live scan fingerprinting receipt dated 2/16/24 documents R4 was fingerprinted. There is no documentation of these results or an Identified Offender Report and Recommendations for R4. There is no documentation that the facility conducted criminal history background checks and fingerprinting for R4 after admitting to the facility on 9/17/24.

R4's Care Plan revised 10/14/24 does not address R4's physically aggressive behaviors or R4's criminal conviction history.

On 10/16/24 at 8:01 AM R4 was in a private room on the locked dementia unit. R4 was lying in bed with R4's wheeled walker within reach.

On 10/16/24 at 10:23 AM V1 Administrator in Training stated corporate staff complete resident background checks. V1 stated V1 was aware of R4's criminal convictions identified on R4's 2/13/24 criminal history report, but V1 forgot to follow up on this. V1 stated R4 transferred from a sister facility, which is why R4's background checks were completed in February 2024. At 2:15 PM V1 stated V1 contacted the State Police today and was told R4 would need to be finger-printed again, so V1 is going to set that up.

The facility's undated Midnight Census, provided by V1 on 10/16/24, documents R1-R6 and R8-R14 reside on the facility's locked dementia unit.

The facility's Identified Offender policy dated 2/16/12 documents to check the resident's name on the Illinois Sex Offender Registration and Illinois Department of Correction Sex Registrant websites, and conduct a Criminal History

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009765	A. BUILDING: _____ B. WING _____	C 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 25 Background Check within 24 hours of admission. This policy documents that if the resident is identified to be an Identified Offender, the facility must request a fingerprint check within 72 hours and complete and submit the Illinois Department of Public Health Identified Offender Form. (C)	S9999		