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S 000	Initial Comments Complaints Investigations: 23910334/IL167688 23810507/IL167902	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3: 300.615(e) 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 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) These Regulations are not met as evidenced by: Based on interviews and records reviewed the facility failed to complete background checks within 24 hours of admission. This failure has the potential to affect all 64 residents residing in the facility. The findings include: Review of Admit Report dated 11/1/23-2/2/24	S9999		

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completed. Requested background checks on R19-R23.

On 2/2/24 at 2:06PM V16 said we don't have any background checks. V16 said looks like it has been for several weeks since the background checks have been done on new admissions. V16 said we don't know if any of the new admissions are Identified Offenders. Anyone who is an identified offenders will be in a room alone. At 2:42PM V16 said the facility does accept identified offenders, but they are placed in a room alone.

According to the census dated 1/30/24 R19 and R22 have room mates.

(C)

Statement of Licensure Violations 2 of 3:
300.610a)
300.1010h)
300.1210b)
300.1210d)3)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.

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S9999	Continued From page 2 Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	S9999		

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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 are not met as evidenced by:

Based on interviews and records reviewed the facility failed to conduct a thorough investigation to explain the origin of bruising for one resident. This affected one of three residents (R5) reviewed for injury of unknown origin. This failure resulted in unexplained black and blue bruising to R5's face and R5 being sent to the local hospital ICU/intensive care unit for treatment.

The findings include:

R5's diagnosis include but are not limited to Hemiplegia and Hemiparesis following other Cerebrovascular Disease, Dementia, Palliative Care, Contusion of Scalp, Subsequent Encounter, and History of falling.

On 1/31/24 at 12:02 PM V9, Certified Nursing Assistant, said when I did rounds R5 was on the floor maybe around 9:40 PM. V9 said I asked R5 what happened and she gestured, V9 demonstrated a gesture, that she rolled out of bed. V9 said R5 was on her right side, and she was close to the bed. V9 said R5 looked like she just slipped out of bed, her legs were still on the bed, and her top half was on the floor. V9 said there was no bumps, no blood, no bruising. V9 said I think V8 was the nurse and we put R5 back in the bed. V9 said R5 had nothing, as far as injury, when we picked her up off the floor. V9

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S9999	Continued From page 4 said I don't know what happened to R5's face. On 1/31/24 at 2:17 PM V8, Registered Nurse (RN), said I was working 2nd shift with R5 on 10/19/23. V8 said R5 did not have a fall. V8 said later I was told the night CNA said R5 had a lot of bruises. V8 said the nurse called me and asked about what she saw. V8 said the night nurse said R5's face had been covered with her hair. V8 said I had already left the facility but when they called me, I came back. V8 said I did not see any blood when I was in the room. I saw a bruise, black and blue on one side of R5's eye. V5 said I wrote an incident report. The next day I called the CNA, V8, myself I asked her about tucking R5 into bed. V8 said V9 said R5 did not fall. V8 said I asked V9 about the bruises on R5's face and V9 said there was no bruise. V8 said V9 never said R5's top body was on the floor and her feet were in the bed. On 2/1/24 at 10:55 AM V5, Restorative Nurse, said R5 had a fall and they sent her out for discoloration on her face. V5 said the root cause of R5 fall was she had a history of trying to get out of bed by herself and ambulate. V5 said the CNA was in the room when R5 fell, and it was a witnessed fall. V5 said floor mats were not in place at the time because I didn't want R5 to trip. V5 said R5 fell because she is confused and has a history of trying to self-ambulate. V5 said R5 must have been trying to reposition herself. V5 said R5 has a history of being non-compliant. At 12:06 PM after V5 requested to review the records V5 returned and said the update to R5's care plan following the fall was to keep personal items in reach and to place her in high traffic areas. V5 said I am not sure if R5 fell on second or third shift. V5 said the Director of Nursing, will give you the investigation for R5.	S9999		

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On 2/1/24 at 11:17AM V6, Director of Nursing (DON), said it was reported to me that they found R5 with an injury on night shift. V6 said I was told it was a fall and I gave it to the restorative nurse for investigation. At 12:07 PM V6 said V31, former Administrator, did the investigation for R5. V6 said the former administrator was the abuse investigator. V6 said I was unavailable during this investigation for R5.

On 2/1/24 at 12:07 PM V13, Regional Director, said we did a reportable for R5 because she had an injury after the fall. V13 said R5 had a bruise. V13 said the nephew voiced concern and called the police so we investigated and did a reportable.

R5's progress notes dated 10/19/23 at 9:48PM documents CNA said R5 was rolling out of bed, and she straightened her back out to make sure she stayed in the bed.

R5's progress notes dated 10/20/23 at 12:51PM documents night staff observed the resident with bruising to the left side of her face and notified the outgoing nurse. Left forehead and left cheek have purplish discoloration. Facial skin was intact. The resident could not tell if she got out of the bed anytime this evening or used the bathroom unassisted. The roommate said she did not observe R5 get out of the bed either. Apparently, the last witness to any of R5's body misalignment was on PM/evening shift when she reported to have been straightened back up in the bed when she was rolled out of the bed.

R5's progress note dated 10/20/23 at 9:27 AM documents the nurse at the hospital said waiting for the doctor to evaluate. According to progress

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notes R5 was readmitted to the facility on 10/24/23.

A safety events report dated 10/19/23 at 11:58 PM documents R5 had a fall from bed to floor during care report documents the fall was witnessed, R5 slipped from bed. Initial injuries state no injuries. Musculoskeletal section indicates normal or consistent with pre fall alignment: yes. If not normal, please fully describe facial show bruises soon developed. Observation of skin on head neck bruising left cheek and left eyebrow. At 12:51 AM night staff observed the resident with bruising to the left side of her face and notified the outgoing nurse the resident left forehead and left cheek have purplish discoloration. V8 documented this report, however V8 said R5 was never on the floor.

Hospital records for R5 dated 10/20/23 identify chief complaint to be a fall. R5 noted to have a large right frontal scalp hematoma along with left orbital edema and ecchymosis. She was admitted to ICU (Intensive Care Unit) for further management.

R5's progress notes dated 10/24/23 document noted with large right frontal scalp hematoma along with left orbital edema and ecchymosis. Bruises all over the face and on the chin. Progress note dated 10/25/23 at 12:04 AM states facial swelling and bruising/ecchymosis noted bilateral eyes and surrounding mouth area, left upper side of forehead with hematoma.

The facility provided a facility reported incident submitted to the State Agency on 10/26/23. The incident category is documented resident neglect. The report documents that R5's family felt they had not been given the "truth" about what

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happened regarding the fall on 10/20/23 and that he had not received timely communication from the facility. The report states that an interview with V9 states she was providing care to R5 on the night of 10/20/23 the resident moved forward without self-stabilizing and rolled from the bed subsequently landing face first on the floor. The report states that V8, RN, stated R5 experienced a fall after rolling from bed which was witnessed by the CNA. V8 and V9 both interviewed by the surveyor said R5 did not fall.

A signed statement from V9 provided to the surveyor on 2/1/24 documents R5 moved forward without self-stabilizing and rolled from the bed. (This is not what V9 said during the interview with the surveyor.)

A signed statement from V8 provided to the surveyor on 2/1/24 documents R5 experienced a fall after rolling from bed which was witnessed per the CNA.

A statement from the V32, LPN, nurse who observed the bruises on 10/20/23 could not be obtained, despite attempts on 2/7/24 9:28AM; 2/1/24 2:56PM and on 1/31/24 at 4:35PM.

The facility Abuse prevention program dated 10/2022 states any allegation of abuse or any incident that results in serious bodily injury will be reported to the State Agency immediately but no more than two hours of the allegation of abuse. An injury of unknown source should be classified when both of the following conditions are met the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury. Final investigation report

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S9999	Continued From page 8 shall contain the following: conclusion of the investigation based on known facts. (A) Statement of Licensure Violations 3 of 3: 300.610a) 300.1010h) 300.1210b) 300.1210d)1)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.	S9999		

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S9999	Continued From page 9 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These Regulations are not met as evidenced by: Based on interview and record review the facility failed follow physician orders for the administration of IV/intravenous medication and obtaining lab blood draw. This failure affected two of three residents (R12, R15) reviewed for physician orders. This failure resulted in R12 not receiving the IV medication for approximately 9 days being sent to the hospital after a change in	S9999		

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condition. R12 was diagnosed and treated at the hospital for Sepsis and UTI (urinary Tract Infection).

Findings include:

1. R12's face sheet shows diagnosis of dementia.

R12's hospital records dated 11/17/23 denotes in-part clinical impression sepsis, UTI, hypernatremia, encephalopathy acute, pulmonary, hypokalemia. Blood culture gram positive bacilli. 83-year-old female presents ER/emergency room from nursing home for altered mental status. She is tachycardic. She apparently was just diagnosed with UTI She is septic from a UTI. She was given 30 cc/kg fluid bolus. She was also given Vanco Zosyn initially, meropenem. IV potassium ordered for hypokalemia. Her lactic is 2.9. Case discussed with hospitalist who accepts admission to IMCU/intermediate care unit with no additional recommendations at this time.

On 2/7/24 at 11:19am V21 (Nurse Practitioner) said she ordered IV (intravenous) antibiotics for R12's positive urine test on 11/18/23. V21 said she did not get a call from the facility stating that there was an issue with ordering the antibiotics, she did not get a call stating there was an issue with starting an IV on R12 either, V21 said she did not get a call stating there was an issue with the antibiotics that she had ordered for R12. V21 said she was under the assumption that the medication had been started.

On 2/7/24 at 1:38pm V28 (medical doctor) said his expectation is that the facility implements orders as prescribed. V28 said an untreated urinary tract infection can contribute to sepsis.

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V28 said 9 days is a long time for no treatment. V28 said he treats a positive urine analysis on a case-by-case scenario, and when the culture comes back, he would adjust the antibiotics accordingly.

On 2/6/2024 at 12:49 V24 (owner of medical assay labs), review of R12 lab report with V24 (V24 said he logged into his system to review with surveyor). V24 said R12 urine analysis was completed first and it showed positive for nitrites, V24 said the urine sample was cultured and it grew bacteria and continued to grow bacteria. V24 explained that urine culture would usually show growth in 24 hours but R12's culture continued to grow bacteria. V24 said on 11/13/23 the urine culture was final, V24 said the facility was made aware of the positive urine analysis and positive urine culture and sensitivity on 11/13/23.

R12 progress notes dated 11/18/23 denotes in-part resident admitted to (hospital name) Dx (diagnosis) sepsis.

R12 progress notes dated 11/17/23 at 8:05pm denotes in-part resident family requested that the resident be sent out to the hospital because she's not responding to verbal command as usual. DON (Director of Nursing) and NP (Nurse practitioner) notified. 911 is here to transport resident to local hospital. VS WNL (vital signs within normal limits).

R12 progress note dated 11/17/23 denotes in part writer received resident UA (urine analysis) results, new order per V21 NP (Nurse practitioner), Imipenem IV for 5 days. (name) aware.

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R12 physician order sheet dated 11/3/23 denotes orders for UA with culture once, one time. 11/17/23 Imipenem-cilastatin recon solution 500 mg, intravenously, special instruction; UTI/ECOLI, every eight hours, 5:00am, 1:00pm, 9:00pm.

Review of R12 medical assay laboratory (3 pages) results report dated 11/7/23 denotes in-part urinalysis color: amber, clarity: cloudy, blood: small, leukocytes; small, nitrites: positive, run by (XH) on November 7 2023 , time 4:13pm. Culture; source- urine, report status final; greater than 100,000 col/ml Escherichia coli, run by (XH) November 13, 2023, time 12:03pm, sensitivity run by (XH) November 13, 2023 , time 12:05pm (medication that are sensitive to organism are listed). Imipenem is circled, there's a handwritten date of 11/8/23, signature of V21 with credentials, orders for potassium chloride 20MEQ x 3days is noted and orders for IV imipenem 500mg Q (every) 8 hours for 5 days is noted.

Request was made to review all of R12's lab reports for November 2023. V6 (director of Nursing) presented 4 reports only. Stating that's all she has for R12.

Facility policy titled change in residents' condition or status denotes in-part our facility shall promptly notify the residents, consult with his or her attending physician, and notify consistent with his authority, the resident representative of changes in the residents medical/mental condition and or status.

Facility policy titled physician orders dated 4/22/2022 denotes in-part all resident medications and treatments must be ordered by a licensed physician or Nurse Practitioner. All medications administered to the resident must be

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRI-STATE VILLAGE NRSG & RHB	2500 EAST 175TH STREET LANSING, IL 60438

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13	S9999		

ordered by the resident's attending physician or Nurse Practitioner. The nursing staff member who took the verbal, telephone, written order, or the one assigned to the resident is responsible to transcribe the order. Transcribing the order includes writing new orders on the Medication Administration Record (MAR), or Treatment Administration Record (TAR), or completing laboratory test requests, dietary notification form, or ancillary notification to inform others of the change in order as necessary. For facilities on EMR, orders must be promptly entered into computer and attached to appropriate Flowsheet(s), i.e., Medication, Treatment or Lab Flowsheet. Nursing staff will follow physician orders. In an event were a resident refuses medication or treatment, or medication is not available. Physician or Nurse Practitioner will be notified.

Review of R12 progress notes presented by V6, there is no documentation denoting R12 refused the IV antibiotics imipenem 500 mg on 11/8/23, 11/9/23, 11/10/23, 11/11/23, 11/12/23, 11/13/23, 11/14/23, 11/15/23, 11/16/23.

On 2/7/24 at 1:59pm V29 (pharmacy representative) said the pharmacy did not delivery R12's medication to facility until 11/18/23.
2. R15's diagnosis include, but are not limited to dementia, end stage renal disease, and dependence on renal dialysis.

On 2/2/24 at 11:37AM V6, Director of Nursing (DON), said I don't have the labs for R15 in the facility. V6 said the labs are not in the lab portal. At 12:00PM V6 said the lab said the last result they have for R15 is on 11/7/23. V6 said R15 has orders for labs on 12/5/23. V6 said the labs should have been done on 12/6/23. V6 said the

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S9999	Continued From page 14	S9999		

physician was called on 12/5/23 because R15 had a change in condition. V6 said the nurses should have called the lab when the labs were not drawn on 12/6/23.

On 2/2/24 at 11:40AM V30, Licensed Practical Nurse, said the lab is here every day. V30 said we place the order in the computer. V30 said the lab will be here the next day unless the lab is scheduled for a particular day.

On 2/7/24 at 1:45PM V26, Doctor, said when labs are ordered, I anticipate the labs will get done.

Progress Note dated 12/5/23 R15 complaints about tired and pain all day long. Face swollen, notified doctor. Received order for CBC, CMP, Magnesium, Phosphorus, Lipid, TSH, B12, Folic, Vitamin D, and Urine with Culture.

Physician order dated 12/5/23 states CBC, Comprehensive Metabolic Panel, Lipid Profile, Magnesium, Phosphorus, Thyroid Stimulating Hormone, Urinalysis, Vitamin B12, and Vitamin D1.

(A)