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S 000	Initial Comments Complaint Investigation: 2490266/ IL168607 2490338/ IL168689 2490390/ IL168756 2490442/ IL168814 2491081/ IL 169609	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 4) 300.610a) 300.1210b) 300.1210c) 300.3240e) 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	S9999		

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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.

Section 300.3240 Abuse and Neglect

e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to monitor, supervise and protect a resident from sexual abuse from another resident when both residents were found engaging in inappropriate behavior in bed earlier that same day. This failure resulted in R13 found with her breast exposed and R6 poking R13's genitals

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through R13's clothes. This failure affected 1 resident (R13) of 2 residents reviewed for sexual abuse in a total sample of 21.

Findings include:

On 2-8-24 at 9:02 AM, V1 (Admin) said staff reported the incident and V1 was on duty at that time. V1 said CNA found both residents fully clothed in bed and R13's leg was resting over R6's hand. V1 said CNA removed R13 from the room and brought to dining room. R13 was brought to dining room for closer observation. V1 said R6 and R13 are non-decisional and unable to give consent. V1 said she is unsure if R6 was being monitored. V1 said this was before mealtime and staff was passing trays. Minutes later, CNA found R6 and R13 sitting in R6's bed, R6 was poking R13's genitals through her clothes.

On 2-7-24 at 10:46 AM, V2 (Director of Nursing) said CNA reported both residents were found in R6's room around 3:30 or 4:00 PM. V2 said CNA said R6 was on top of R13 and both were fully clothed. V2 said the CNA immediately separated the two residents and both placed in dining room at opposite sides for monitoring and during the process of a room change. V2 said CNA broke the couple up because both residents are confused and both residents could not consent to this. At 4:30 PM, both residents walked to R6's room. V2 said CNA observed both residents on the bed and CNA reported that she saw R6 poking his fingers between R13's legs with her pants on.

On 2-8-24 at 10:30 AM, V29 (LPN) said around the beginning of shift (3:30 PM) the CNA called V29. V29 said she came to R6's room and saw

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S9999	Continued From page 3 R6 and R13 sitting on R6's bed. R6 was sitting close to R13. Both R6 and R13 were clothed however, R13's shirt was slightly up and a breast was exposed. V29 said R13's legs were open but clothes were on. On 2-7-24 at 9:03 AM, V15 (CNA) said around 6:00 PM, she made rounds and saw R6's door slightly open. V15 said she went into R6's room and saw R13 (fully clothed) in R6's bed. R6 was sitting at the foot of the bed. V15 saw R6 poking R13's genital area with her pants on. V15 saw R13 refusing and saying "No." V15 said R6 stopped when he saw V15 enter the room. Initial State Reportable (dated 1-10-24) documents: At approximately 5pm staff reported that (R6) and (R13) both confused residents were in (R6's) room laying on his bed. (R13's) shirt was up exposing her breasts and his hand was placed on her genital area on top of her clothes. Both residents were immediately separated and placed on 1:1. Final State Reportable (dated 1-18-24) documents: after a thorough investigation of residents medical records, staff, and resident interviews it has been determined this allegation is unfounded. Both residents have a cognitive impairment, are confused, and has a diagnosis of Dementia. Neither resident was able to recall any interactions with the other resident. Staff interviews conducted and staff deny seeing any inappropriate or sexual behaviors noted for either resident. ER report for (R13) states a full body assessment was completed and there were no clinical signs for physical or sexual trauma and was cleared to return to facility. At the time of alleged incident (R6) was immediately moved to another unit and residents remain separated.	S9999		

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Both residents immediately placed on enhanced supervision (1:1) and will continue until further orders from physician. Care plans have been reviewed and revised as necessary.

R13's Hospital Record dated 1-10-24 documents: Assessment/Plan/MDM: 77-year-old who presents for wellness examination. Afebrile, hemodynamically stable, nontoxic in NAD, saturating well on RA. Full body exam without clinical signs for physical or sexual trauma. Pt cleared for discharge to NH in stable condition. Subjective: (R13) is a 77y female who presents for wellness check. Pt with hx of advanced dementia, coming from (Facility), Per staff, pt was found in another male patient's room. Staff reports that they found pt on top of male but reports both of their clothes were on. EMS reports clothes were on both of them when they arrived, did note that part of pt's depends diaper was ripped on the side, but sweatpants were still on fully. sent to ER for evaluation. Pt pleasantly demented, difficult to follow pt's train of thought, but she did not mention any concerns for sexual or physical assault. Pt repeatedly requesting that she wants to go home.

Police Report (dated 1-10-24) documents: Narrative: V2 (Director of Nursing) related at appropriately 1545, that a female resident later identified as R13 and a male resident later identified as R6 were caught possibly trying to have sexual relations twice today (1-10-24) and when they were separated R13 was blowing kisses at R6. Both times they were stopped by two different CNAs. V2 further related that both of the above listed residents have dementia and do not recall what occurred. A CNA related she was making rounds checking on the residents and walked into R6's room at approximately 1545hrs

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and observed R6 on top of R13 in between her legs. CNA further related that both residents had their clothes on. CNA then requested help from other staff member and was able to separate both residents. V15 (CNA) related she was making her rounds checking in on the residents when she observed the door on (R6's) room opened slightly and the bathroom door opened as well blocking her view in to the actual room at approximately 1645. V15 entered and observed R13 and R6 were in the bed together. R13 had one of her breasts exposed and R6's hand was rubbing his fingers on the outside of R13's pants near her vagina. V15 asked what they were doing and R6 replied "She's bothering me" V15 requested for other staff members to separate R13 and R6. R6 was then relocated to the fourth floor. V17 (Social Services Director) related that both residents R13 and R6 were both considered non-consenting adults because they are both diagnosed with dementia.

R6's MDS (ARD 1-4-24) documents: BIMS summary score = 6. Active Diagnoses (not limited to): Non-Alzheimer's Dementia, Altered Mental Status, unspecified.

R13's MDS (ARD 12-5-23) documents: BIMS summary score = 9, Active Diagnoses (not limited to): Non-Alzheimer's Dementia, Psychotic Disorder, and Altered Mental Status, unspecified.

Abuse Prevention Program (dated 2-2017) documents: Policy: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, or mistreatment. The facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents.

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S9999	Continued From page 6 (B) Statement of Licensure Violations (2 of 4) 300.610a) 300.3240a) 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on interview and record review, the facility failed to follow their abuse policy by not ensuring one resident (R11) social security checks were returned to the office of social security after being discharged from the facility for four months. This affected one of three residents (R11) reviewed for	S9999		

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misappropriation of funds. This failure resulted in R11's family not receiving two months of social security payments for daily expenses.

Findings include:

R11 was admitted to the facility on 1/4/23. R11 was discharged from the facility on 10/20/23.

R11's resident statement documents on 11/3/23 Social security administration payment of 2030.00 deposited ; on 11/3/23 1800.64 removed from account for care costs. On 12/1/23 social security payment of 2030.00 deposited; on 12/1/23 1800.64 removed from account for care costs. Under status: closed 12/29/23.

On 2/7/24 at 3:12pm, V9 (Business Office Manager) said R11's family came to speak to her some time last week about concerns related to R11's social security checks not being received. V9 said she instructed the family to speak to social security because the check had been returned. V9 said she thought the family was only asking about January social security funds which were already returned and was not aware of the November or December checks not being received by R11.

On 2/6/24 at 4:08PM, V23 (Medicaid specialist) said resident accounts are supposed to be closed when the resident discharges from the facility. The November and December social security income checks for R11 were deposited into the facility account and have not been returned to social security at this time. V23 said the account should have been closed timely to prevent those checks/funds social security from being directly deposited into the account.

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S9999	Continued From page 8 On 2/7/24 at 12:45PM, V22 (R11's family) said she spoke to V9 about concerns related to R11's November and December social security checks and she was referred to go to the social security office because V9 (business office) said the income had been returned. V9 said she reached out to social security office who said the checks had not been returned by the facility. V22 said R11 was living with her and that money was needed to assist with bills and food. V22 said R11 had passed away this week and that money would be needed to help pay for the cost of funeral services. V22 said she is trying to borrow money from other family members to help pay for the services. Facility abuse prevention program dated 2/2017 documents: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. Misappropriation of resident property means the deliberate misplacement, exploitation or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. (B) Statement of Licensure Violations (3 of 4) 300.610a) 300.1210b) 300.1210d)5) Section 300.610 Resident Care Policies	S9999		

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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

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:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's

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clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirements were not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to implement effective pressure prevention interventions. This affected one of three residents (R7) reviewed for pressure sores. This failure resulted in R7 stage 4 pressure ulcer progressing to develop osteomyelitis (an inflammation or swelling of bone tissue this is usually the result of an infection.)

Findings include:

On 2/6/24 at 12:05 PM, V28 (Wound Care Nurse) was observed performing wound care treatment for R7's sacral pressure ulcer. R7's sacral dressing was observed to be nonocclusive on the distal half of dressing. There was bowel movement on top and under R7's dressing. Bowel movement was also observed in R7's wound. R7 was observed to have a flat sheet folded in half twice under R7's buttocks.

On 2/7/24 at 9:30 AM, V28 was observed performing wound care treatment for R7 with V20 (Wound Care Physician). R7 was observed to have a blanket folded twice underneath R7. R7's sacral dressing was covered in old bowel movement.

On 2/7/24 at 9:50 AM, V20 (Wound Care

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Physician) stated that the residents on low air loss mattresses can have one flat sheet and one draw sheet under the resident. V20 stated that blankets and flat sheets folded twice should not be placed underneath the resident. V20 stated that the nurse should change R7's dressing if dressing becomes nonocclusive or soiled after R7 has a bowel movement. V20 stated that R7's ESR (sedimentation rate) and CRP (C-reactive protein) levels are elevated suggesting osteomyelitis (infection in bone) of sacral bone.

On 2/7/24 at 10:45 AM, V2 DON (Director of Nursing) stated that the nurse is expected to change wound dressing if it becomes nonocclusive or soiled. V2 stated that the nurse should document in the resident's electronic medical record if the dressing is changed.

On 2/8/24 at 2:45 PM, V3 LPN (Licensed Practical Nurse) stated that some CNAs (Certified Nurse Aides) will notify V3 if R7's sacral dressing becomes soiled and needs dressing changed.

R7's POS (Physician Order Sheet), notes an order, dated 1/7/24, for sacrum - stage 4 pressure wound, clean with normal saline, dry with gauze, apply alginate calcium with silver, cover with ABD pad and tape, change dressing daily and as needed. This order was discontinued on 1/15/24.

Upon R7's re-admission on 1/16/24, there were no orders for wound care treatments obtained until 1/18/24 at 4:00 PM. On 1/18, sacrum - stage 4 pressure wound, clean with normal saline, dry with gauze, apply alginate calcium with silver, cover with ABD pad and tape, change dressing daily and as needed was ordered. This order was discontinued on 1/27; re-ordered on

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1/28; and discontinued again on 1/30.

R7's POS, dated 1/19/24, notes an order for sacrum - stage 4 pressure wound, clean with normal saline, dry with gauze, apply dakins soaked gauze, cover with ABD pad and tape, change dressing daily and as needed. This order was discontinued on 1/27 and re-ordered on 1/30.

R7's POS, dated 2/7/24, notes an order for Levofloxacin (antibiotic) 750mg (milligrams) via gastrostomy tube daily x 14 days for osteomyelitis.

R7's TAR (Treatment Administration Record), dated January and February 2024, notes R7's sacrum stage 4 pressure ulcer did not receive wound care treatment on 1/7, 1/9, 1/13, 1/17, 1/18, 1/29, 2/2, 2/3, 2/4, or 2/5.

R7's medical record, dated 1/13/24, notes R7 was transported to the hospital at 3:54 PM. R7 was re-admitted to this facility on 1/16/24 at 5:50pm.

V20 (Wound Care Physician) note, dated 1/31/24, notes R7 with a stage 4 sacral pressure ulcer, measuring 14cm (centimeters) x 12cm x 2.4cm, moderate serosanguinous (clear blood tinged yellow fluid) drainage, 100% granulation tissue. A factor affecting wound healing is fecal incontinence.

V20 (Wound Care Physician) note, dated 2/7/24, notes R7 with a stage 4 sacral pressure ulcer, measuring 14cm x 10.5cm x 2.4cm, heavy serous (clear yellow fluid) drainage, thick adherent devitalized necrotic (dead) tissue 10%, granulation tissue 80%, fascia (band of connective tissue) 10%. ESR (sedimentation

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(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		

rate) was very elevated (134) and CRP (C-reactive protein) was also elevated suggestive of underlying osteomyelitis. Plan: start antibiotics to treat osteomyelitis.

R7's laboratory test results, dated 2/1/24, notes CRP 1.6 (normal range 0.1-0.9) and ESR 134 (normal range 0-20).

R7's MDS, (Minimum Data Set), dated 10/16/23, notes R7's cognition is severely impaired and R7 is dependent on staff for all ADLs (activities of daily living). R7 is always incontinent of bowel.

R7's skin care plan, initiated 7/14/23, notes R7 is at risk for skin breakdown due to limited mobility. R7 also has a pressure ulcer to sacrum.

R7 does not have a care plan related to bowel incontinence.

(A)

Statement of Licensure Violations (4 of 4)

300.610a)
300.1010h)
300.1210b)

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

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	IL6008270	A. BUILDING: _____ B. WING _____	C 02/21/2024

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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.

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.

Based on interviews and record reviews, the facility failed to notify the physician of abnormal laboratory test results for one resident (R7) out of

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S9999	Continued From page 15	S9999		

three reviewed for physician notification in a sample of 18. R7's elevated sodium level (sodium 151, normal range is 135-145) was reported to this facility on 1/17/24 at 4:02pm and not reviewed by nursing staff until 1/18/24 at 2:54 AM. This result was not communicated to R7's physician prior to R7 being admitted to the hospital on 1/19/24 at 9:20pm with diagnoses including dehydration and elevated sodium level (sodium 158).

Findings include:

On 2/8/24 at 1:50 PM, V35 NP (Nurse Practitioner) stated that V35 would expect the nurse to notify her of all abnormal laboratory results. V35 denied being made aware that R7's sodium level was elevated (151) on 1/17/24. V35 stated that she would have given the nurse an order to start intravenous fluids to reduce R7's sodium level to within normal range. V35 stated that V35 also would have ordered follow up laboratory testing to monitor R7's sodium level.

On 2/8/24 at 1:55 PM, V34 NP stated that V34 expects the nurse to call with all abnormal laboratory results.

On 2/8/24 at 2:45 PM, V3 LPN (Licensed Practical Nurse) stated that every nurse should check the dashboard in assigned residents' electronic medical record to see if any laboratory results have been reported and if any are abnormal. V3 stated that the nurse should note any test results reviewed and relay results to the NP or Physician. V3 stated that there is no way to know if test results have been reviewed by the nurse and relayed to the NP/Physician, if the nurse does not document this has been done. V3 stated that R7 has a gastrostomy tube and

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S9999	Continued From page 16 receives water flushes for hydration. V3 stated that he does not recall seeing R7's laboratory results from 1/17/24. V3 stated that V3 was not aware R7's sodium level was elevated. V3 stated that the nurse should call all abnormal laboratory results. R7's laboratory test results, dated 1/17/24, were reported/uploaded into R7's electronic medical record at 4:02 PM and were flagged with a yellow triangle symbol noting abnormal test results. R7's sodium level was 151 (normal range is 135-148). On 1/13/24, R7's sodium level was 141. R7's hospital record, dated 1/19/24 - 1/28/24, notes R7's sodium level was 158. R7 was admitted to the intensive care unit with diagnoses dehydration and elevated sodium level. R7 was treated with intravenous fluids and increased water flushes via gastrostomy tube to decrease R7's sodium level. (B)	S9999		