STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003008	A. BUILDING: _____ B. WING _____	C 04/12/2024

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S 000	Initial Comments Complaint Survey: 2398068/IL164884, FRI of 2/23/2024/IL170256, FRI of 8/6/2023/IL163403 & FRI of 5/1/2023/IL162624	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 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	S9999		

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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 Requirements were NOT MET as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to safely reposition a resident during direct resident care and failed to ensure supervision of residents with a history of aggression. This affected five of six residents reviewed (R3, R4, R7, R8, & R9) reviewed for supervision and safety. This failure resulted in R9 rolling from the bed while receiving incontinence care sustaining a laceration to the head and treated at the local hospital. The failure also resulted in R4 attacking R3 with a butter knife, and R8 throwing a walker and striking R7.

Based on interview and record review the facility failed to follow their elopement policy by not contacting the local police for one resident. This affected one of three residents (R14) reviewed for resident safety. This failure resulted in R14 not returning from an independent community pass and the facility failed to notify the local police.

Findings include:

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R9:
On 4/2/24 at 1:00 PM, R9 was observed laying in bed. R9 was observed to have eyes open and is nonverbal.

On 4/2/24, V18 (falls nurse) stated that all residents are assessed for their risk for falls upon admission and re-admission to this facility. V18 stated that staff will notify her if there is a resident fall incident. V18 stated that there is a falls binder at each nurses' station that identifies a resident's fall risk and interventions in place. V18 stated that she determines the root cause of the fall and reviews fall interventions currently in place and implements additional interventions as needed.V18 stated that R9 had a fall incident while receiving care. V18 stated that V19 CNA (certified nurse aide) did not project enough space between V19 and R9's bed. V18 stated that there were two CNAs providing care at the time of the incident. V18 stated that R9 sustained a laceration to head requiring sutures.

On 4/4/24, V19 CNA stated that she and V20 CNA were providing incontinence care to R9 at the time of the incident. V19 stated that she was positioned on the right side of the bed. V19 stated that she and V20 turned R9 onto his right side. V19 stated that she misjudged the amount of bed space between her and R9; V19 thought there was enough room for R9 to be turned. V19 stated that she attempted to hold onto R9, but was unable to prevent R9 from falling. V19 stated that R9 rolled on top of her and hit his head on the night stand next to bed. V19 stated that V20 ran and got R9's nurse. V19 stated that R9 is totally dependent on staff for all ADLs (activities of daily living). V19 stated that a mechanical lift device was used to get R9 back in

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bed after nurse assessed him for injuries. V19 stated that R9 was transported to the hospital for further evaluation.

On 4/5/24, V31 LPN (licensed practical nurse) stated that V31 was R9's nurse at the time of the fall incident. V31 stated that there were two CNAs providing care to R9 at the time of incident. V31 stated that V31, a co-worker, and V3 DON (director of nursing) were present near R9's room at the time of the incident. V31 stated that V20 notified her that R9 fell. V31 stated that she and V3 went to R9's room immediately. V31 stated that R9 was laying on his side next to his bed. V31 stated that she performed a head to toe assessment and observed R9 with a mid to left forehead laceration. V31 stated that R9's vital signs were stable and there was no change in level of consciousness. V31 stated that compression was applied to stop bleeding. V31 stated that R9 is unable to communicate due to his history of stroke. V31 stated that R9 did not grimace with pain upon palpation. V31 stated that the mechanical lift device was used to lift R9 into bed. V31 stated that R9 was transported to the hospital via EMS (emergency medical services) 911 for further evaluation. V31 stated that R9 returned to this facility later same day with sutures to forehead.

On 4/9/24 at 4:26 PM, V20 CNA stated that he was called to assist V19 CNA with providing incontinence care to R9. V20 stated that he was standing on the side of the bed closest to the window (left side of bed). V20 stated that V19 CNA was standing on the right side of bed. V20 stated that they rolled R9 onto his right side and R9 continued to roll out of bed. V20 stated that V19 CNA attempted to catch R9, but was unsuccessful. V20 stated that R9 hit his head on

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the nightstand before landing on top of V19 CNA. V20 stated that he immediately looked outside R9's room and called for assistance. V20 stated that V31 LPN came to the room and he assisted V31 with rolling R9 off of V19 CNA and placing sling under R9. V20 stated that V31 assessed R9 and then R9 was lifted onto bed using the mechanical lift device.

On 4/10/24 at 12:50 PM, V3 DON (director of nursing) stated that she was present on the nursing unit at the time of R9's fall incident. V3 stated that she responded with V31 LPN to R9's room. V3 stated that upon entering R9's room, R9 was observed laying on top of V19. R9 sustained a laceration to forehead. V3 stated that when R9 was being turned onto right side, V19 was unable to stabilize R9 on his side and R9 rolled out of bed.

R9's ADL care plan, initiated 5/19/2020, notes R9 has an ADL performance deficit and impaired mobility related to paraplegia, gastrostomy tube, and tracheostomy. It notes R9 requires two staff participation to reposition and turn in bed. R9 has a self care deficit needing total assistance with all ADLs.

R9's falls care plan, initiated 6/27/2019, notes R9 is at high risk for falls related to poor trunk control, paraplegia, and seizures.

R3 and R4:
On 3/29/24 at 1:10pm, R3 was assessed to be alert and oriented x 3. R3 stated that his previous roommate, R4, and he got into a verbal altercation over the volume of the television. R3 stated that R4 then picked up a butter knife and was swinging it at R3. R3 stated that R4 cut him

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on his head with the butter knife. R3 stated that he informed V24 (former administrator) of this incident. R3 stated that he and R4 were separated. R3 stated that he went to the dining area and R4 remained in R3 and R4's room until R4 was transported to the hospital for psychiatric evaluation. R3 stated that he informed his case manager of this incident on 7/26/23 and she reported it to facility.

R3's BIMS (brief interview of mental status) score, dated 3/5/24, notes R3's score is 15 out of 15. R3 is cognitively intact and able to make needs known.

This facility's investigation of the allegation of physical abuse involving R3 and R4, dated 7/26/23, notes R3 reported the incident involving R4 to his case manager on 7/26/23. R3 reported that he had a disagreement some months ago with his previous roommate, R4, regarding the volume of the television. During this disagreement R4 attempted to stab him. R3 stated that staff immediately separated both residents. Police were notified. V27 (former ADON - assistant director of nursing) was interviewed on 7/26/23. V27 stated she was made aware of the disagreement between R3 and R4 on 5/1/23. V27 stated when she arrived on the nursing unit, the residents were separated. R4 in room being monitored and R3 went to the common area. V27 stated R4 was delusional and not re-directable at that time. R4 went to hospital for psychiatric evaluation. V44 (agency nurse) was interviewed. V44 heard R3 yelling in his room 'R4 is stabbing me'. The report V44 gave to the emergency department was she was sending R4 out for aggressive behavior towards roommate, R3, and needed evaluation. The butter knife scraped R3 when she did the skin

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assessment.

On 5/1/23 at 6:15 PM, R4 was petitioned out by V27 (former ADON) and V28 (former DON).

R4's medical record notes the following:
On 4/12/23 at 4:35 PM, V45 (former social services) notes V45 witnessed R4 expressing delusions and attempting to be aggressive with another resident. V45 re-directed R4, counseled on behavior and made staff aware. Staff will monitor for aggressive actions.
On 5/1/23 at 6:39pm, V28 (former DON - director of nursing) noted R3 had dispute with roommate, R4, related to the volume of the television in the room. Staff responded to the dispute and separated the two residents. R4 received medication for agitation. Order received for R4 to be transported to hospital for psychiatric evaluation. Well-being check was conducted on R3. R3 currently in dining room watching television.
On 5/8/23 R4 re-admitted to facility. R4 and roommate, R3, not getting along and R4 requested a new room. Placed in room on another nursing unit temporarily until morning staff can change room.
On 5/11/23 at 6:32 AM, V47 NP (nurse practitioner) noted per staff, R4 is a re-admit after becoming aggressive with staff and residents. He was sent out on a psychiatric evaluation and came back on more medications. R4 had to change room assignments on his first night back, 5/8, after becoming aggressive towards roommate (R3).

R4's hospital record, dated 5/2/23-5/8/23, the psychiatric physician noted R4 with a long-standing history of very poorly controlled bipolar disorder and delirium. R4 presented to

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the emergency department on 5/1/23 after R4 grabbed a knife and threatened R3 with it. The facility feels R4 is in danger of hurting someone. R4 has a low threshold for confrontational behavior.

R4's care plan for the presence of abuse and neglect factors, initiated 9/24/2020, notes R4 presents with a host of medical problems and psychiatric history. R4 presents with a risk for becoming a perpetrator of abuse. R4 is known to become upset/agitated and requires medication management and supervision/attention on the unit.

R4's behavior symptoms/inappropriate boundaries care plan, initiated 2/3/2023, notes R4 has threatened physical aggression toward peers.

R4's history of aggressive/inappropriate behavior care plan, initiated 9/24/2020, notes R4 has a history of aggressive, inappropriate, and/or maladaptive behavior. R4 has history of conflicts/altercations with others, exhibiting delusional behaviors toward others, and acting erratically.

R7 and R8:
On 4/2/24 at 1:15 PM, R7 was assessed to be alert and oriented x 3. R7 stated that R8 came to his room and began yelling at him. R7 stated that R8 then picked up his walker and threw it at R7. R7 stated that he raised his arms to block the walker from hitting him. R7 stated that the walker hit his left arm causing bruising. R7 denied any staff member being in R7's room at the time of this incident. R7 stated that he informed the V24 (former administrator) of the incident.

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The facility's abuse investigation, dated 8/6/23 at 6:55pm, notes R7 reported to V40 (manager on duty) that R8 entered his room and allegedly stated to R7 "mind your f***ing business, you are always in my f***ing business" and flung his walker at R7. R7 assessed and observed to have bruise to left arm. X-ray ordered. R8 was sent to the hospital for psychiatric evaluation. R8 placed on 1:1 monitoring until transported to hospital. R7 interview noted R7 was sitting on edge of bed with R7's walker in front of him. R8 picked up walker and threw it, R7 raised left arm to block walker causing bruise on left arm. CNA (certified nurse aide) in room at time of incident and responded immediately to separate residents. V32 CNA was interviewed at the time of this incident. V32 stated that he was in R7's room behind privacy curtain. V32 stated that he heard residents yelling at each other. V32 stated that he did not hear what they were saying. V32 denied witnessing R8 throw walker at R7. V39 (agency nurse) was interviewed at the time of this incident. V39 stated that she did not witness the alleged occurrence. V39 stated that she was informed that both residents were hollering at each other and it was a verbal disagreement. R7 reported incident to V40 during her rounds and V40 reported incident to V39.

R7's medical records, dated 8/6/23 at 6:41 PM, V39 (agency nurse) noted V39 made aware by R7 that he was in a verbal altercation with R8 and stated that the R8 "threw his walker at me". Head to toe assessment completed for injuries, dark red bruising and small skin tear with scant bleeding noted to the left lower arm. As needed acetaminophen given as ordered for comfort. Skin tear cleaned with normal saline solution and bacitracin ointment applied. Physician on call made aware and ordered for urgent x-ray for the

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lower left arm.

R8's history of aggressive/inappropriate behavior care plan notes R8 has a history of aggressive, inappropriate, attention-seeking and/or maladaptive behavior by becoming easily agitated and exhibiting poor impulse control, as evidenced by exhibiting with covert/open conflict, general intolerance and limited ability to deal with frustration and a history of substance abuse.

R8's mood distress-conflict with other persons care plan, notes R8 displays conflictual, difficult behavior with peers and staff. R8 exhibits a difficult time adjusting to life in the long-term care facility, complaints/concerns about other residents, general intolerance and limited ability to deal with frustration and a history of substance abuse.

R14 was admitted to the facility on 4/8/23 with a diagnosis of cocaine dependence, schizophrenia, major depressive disorder, panic disorder, and depression. R14's brief interview for mental status score documents a score of 14/15 which indicates cognitively intact.

R14's progress notes dated 10/15/23 at 10:47PM: R14 went out on pass and did not return at scheduled time. Writer and receptionist attempted to call patient and phone going straight to voicemail and unable to leave message. V42(MD), V22(previous DON) and V24 (administrator) made aware. There was no other notes on 10/15/23 documenting resident out on pass or any other details.

On 4/9/24 at 4:01pm, V43(nurse)said when a resident does not return from pass, staff would call resident, family, police, management. V43

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said she recall calling V24(former administrator) and she reported that R14 had done this before and not to call the police. V24 said they would handle the situation. V43 does not recall anyone saying the resident left against medical advice. R14's progress notes dated 10/16/23 at 6:06AM: The resident has not returned to the facility from being out on pass. Local hospital and emergency contacts were contacted by writer but no answer.

There were no other progress notes documented in R14's medical record until 10/24/23.

R14's progress notes dated 10/24/23 at 10:56AM: Writer attempted to contact emergency contacts on file in attempt to gather an update on resident. Writer unable to make contact or gather any information. Writer then proceeded to contact the V36(NP) letting her know that resident is still not back from being on independent pass and was given the directive to contact the police. Administration notified and verbalized that resident signed a release of responsibility form prior to leaving the facility and that there is no need to contact the local police. Resident was Alert and oriented x3 prior to leaving facility per staff. V36(NP) notified and in agreeance with carried out protocol.

On 4/5/24 at 3:10Pm, V36(NP) said she was notified of the resident not returning from pass but unsure of the date called . She gave the initial order to call the police but after discussion with Director of nursing and administrator at that time they said the resident signed a responsibility for self paperwork prior to leaving and there was no need to call the police. If paperwork was not signed I would expect the facility to contact the police for a resident in case they are missing.

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On 4/10/24 at 10:36AM, V2(Assistant administrator) said that when residents leave on pass they sign a release of responsibility form. If a resident does not return, staff will attempt to call resident, family, hospitals, police and filing a missing person report within 24 hours of not returning. V2 was asked why the police were not contacted for R14 and said because R14 had contact with V24(Administrator) and expressed he was not going to return. V2 said that the information should be documented but it was a personal situation with V24(Administrator) and V24 was handling this situation.

On 4/10/24 at 1:00PM, V1(Administrator) said they have no other documents related to R14. R14 said the release form is the same form former facility would have been utilizing and are unable to provide this document for R14.

On 4/10/24 at 1:44PM, V24(former administrator) said if a resident does not return from pass, facility would attempt to reach out to resident, family, try to search area and contact the police to assist with the search. Due to R14's history of not returning from pass, he was considered leaving against medical advice and the police were not contacted. V24 said if the V36(NP) instructed staff to contact the police they should have been contacted. V24 was unable to answer why there was no other documentation from 10/16/23 to 10/24/23 in regards to R14. V24 said she was unaware of R14 whereabouts or location and did not have any contact with R14 after him not returning from pass.V24 was asked how did they determine the resident left against medical advice versus was not harmed while out of the facility. V24 said that she was new to facility and facility tried to locate R14. V24 said she reached out to R14 family and due to history of not returning he

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S9999	Continued From page 12 was considered leaving against medical advice. Facility elopement policy reviewed 8/1/23 documents: Facility intends to establish an organized approach to search for a resident who is potentially missing to ensure that if a resident is found to be missing that the appropriate authorities are notified. If search of rooms and grounds fail the following will be initiated: notify the police. (B)	S9999		