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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: One of Three 300.3210a) 300.3240f) Section 300.3210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of a facility. (Section 2-101 of the Act) Section 300.3240 Abuse and Neglect f) A facility that becomes aware of photographing or recording of a resident, without the resident's consent or knowledge, or any other abuse, shall comply with subsections (a) through (e) of this Section. This REQUIREMENT is not met as evidenced by: I. Based on interview and record review, the facility failed to develop their abuse prevention policy to include the prohibition against the use of technology, photographing, or recording of residents to facilitate or enable abuse or mental abuse. This failure has the potential to affect all 48 residents residing in the facility. Findings include:	S9999		

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The facility's Resident Roster dated 1/16/24 documents 48 residents reside in the facility.

The facility's Abuse Prevention and Prohibition policy dated 12/22/16 documents this policy is applicable to all departments and nursing units of the facility including The Meadowbrook Skilled Care, and the Skilled Care Greenhouse units. This same policy does not include a prohibition regarding the use of technology, photographing, or recording of residents to facilitate or enable resident abuse or mental abuse.

On 1/16/24 at 2:16 PM V1 (Assistant Administrator) stated, "That is the most recent up-to-date abuse prevention policy."

"C"

Two of Three

300.1210b)
300.1210d)6)

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

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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:

II. Based on observation interview and record review the facility failed to provide a safe environment which required emergency medical services at a local hospital. The facility also failed to provide a timely mechanical lift transfer and adequate supervision to prevent fall for one of one resident (R997) reviewed for falls on the sample list of three.

Findings include:

1.) R997's "Admission Summary" dated 9/29/2023 at 7:05pm documents R997 was admitted from a local hospital 'post hip left fracture repair'.

R997's Minimum Data Set (MDS) dated 10/05/23 documents R997 Brief Interview of Mental Status score of 00 (zero) out of a possible 15, indicating severe cognitive impairment. The same MDS documents R997 had a fall with major injury, within the one month of admission (9/29/23) resulting in a fracture from a fall.

R997's Diagnoses Sheet on admission 9/29/23, included the following diagnoses: Nondisplaced Intertrochanteric Fracture of Left Femur, Subsequent Encounter for Closed Fracture with

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Routine Healing, Age Related Osteoporosis Without Current Pathological Fracture, Muscle Wasting and Atrophy, Not Elsewhere Classified, Difficulty Walking, Not Elsewhere Classified, Cognitive Communication Deficit, Anxiety Disorder, Unspecified, and Vascular Dementia, Unspecified Severity, With Other Behavioral Disturbances.

On 01/16/24 at 10:50 am R997 was seated in a wheelchair in her room. V10 (Caregiver) stated V10 is with R997 on day shift. V10 also stated, R997 had a fall over the weekend. V10 stated V10 was told R997 was reaching from the front of her recliner to the side dresser for her glasses (documented as tissues below). V10 stated "The side dresser sets this far (points to the distance, five feet from recliner and contains R997's eyeglass case and a box of tissues) and always has. Of course, she (R997) could not reach it. I doubt her call light was within reach either. When she is in the recliner, I have never seen it (call light) within her reach. Even if it (call light) was, (R997) probably would not remember to turn it on." V10 stated "When (R997) is in bed, there is this camera (shows a camera on top of the same side dresser) they can watch from the nurses station. Since she (R997) fell from the recliner, the camera is pointed in the opposite direction, and would not have shown her fall. My concern is how long she may have laid there waiting for help."

R997's "Incident Note" dated 01/06/2024 at 11:30 am documents the following:
"Note Text: This nurse (V2 Director of Nursing/DON) was walking in the hall and heard resident (R997) calling for help. Upon entering (R997's) room resident was noted to be sitting on the floor on (sic) the room, leaning with her back

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against the recliner. Resident (R997) had her call light attached to her sweater. Resident assisted into a laying position with pillows under her head. Resident alert and oriented to baseline. No obvious signs of injury noted while on floor. Resident was (sic) to bed via (mechanical lift). Upon nurse (V2 DON's) assessment while in bed, resident complained of pain to left knee and left hip area while performing ROM (Range of Motion). When asked to rate pain resident stated, 'it's not too bad'. Nurse (V2) noticed shorting to left leg and a small bulging area upon palpitation. Resident had just been assisted to recliner approximately 10 minutes prior to fall. Resident call light with reach but not activated, resident fully clothed with nonskid footwear in place, resident was continent at time of fall. Resident assisted into bed. On Call Provider (unidentified) notified. V17(Power of Attorney/POA) notified. Hospice (unidentified end of life service) MOD (unidentified Manager on Duty) notified. Resident (R997) sent out to hospital for treatment and Evaluation via ambulance at 12:25 pm."
The same "Incident Note" documents the investigation was completed. "Root cause: Poor safety awareness, impulsiveness, (and) personal items out of reach. Intervention: Resident sent to ER (hospital emergency room) for evaluation and treatment. Staff educated to keep personal items within reach of resident while in the recliner."

R997's Hospital report dated 01/06/24 documents R997 required a diagnostic X-ray of the Left Femur to rule out a fracture. No acute findings.

On 1/16/24 at 1:25 pm V2 (Director of Nursing) confirmed R997 had a fall on 01/06/24. The root cause was determined to be, R997's was reaching for her tissues and the tissues were too far away from her when she was in the recliner.

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V2 then enters R997's room and stated, "The dresser is too far away (five feet from recliner) from her (R997) recliner. The (unidentified) CNAs (Certified Nursing Assistants) should have had (R997's) bed side table over by the recliner, with her personal item close to her (R997)."

2.) R997's "Incident Note" dated 01/12/2024 at 11:33 am documents the following:
"Note Text: Res (resident R997) had requested to use the bathroom. CNA (V11) took res to her room but sit-to-stand lift was not available, so she left res in room with call light while she went to get lift. A few minutes later, res was heard yelling. Res noted to be on her bottom on the floor in front of toilet with her pants down and underpants partially down. Shoes on. Res'(resident) w/c (wheelchair) in bathroom a couple feet away from her. Urine noted to be on w/c cushion and floor surrounding the toilet. Res states she fell when trying to get off the toilet. No apparent injuries noted. ROM WNL (Range of Motion Within Normal Limits). Res assisted into w/c via (full mechanical lift) and cleaned up and pants changed. Res then put to bed per her request. APN (V20 Advanced Nurse Practitioner) and res' dtr (daughter) (V17 R997's Family Member/POA) notified of FOF (Found on Floor)."

On 1/16/24 at 1:25 pm, in the same interview documented above, V2 (Director of Nursing) also stated (R997) had a fall 1/12/24 and the root cause was determined to be that the V11 (CNA) did not have the mechanical stand lift available to transfer (R997), which resulted in the resident transferring herself to toilet. V2 also stated V11 left (R997) room knowing the resident needed toileting. The mechanical stand lift on R997 hall was in use. V11 had to go to the other end of the

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hall to get it another mechanical stand lift. V2 stated "I was here and completed the assessment. (R997) wheelchair cushion was saturated in urine and there was urine was on the floor. (R997) had transferred herself. The intervention is to make sure they have all resident supplies at hand including the lift required for transfer."

On 1/17/24 at 4:30 pm V11 (CNA) stated "(R997) was seated by her bed, in her wheelchair, watching television before her (01/12/24) fall. V11 stated "She (R997) said she had to go to the bathroom 'bad'. I moved (R997's) wheelchair from in front of the television, over to the bathroom door and put the (mechanical stand lift) sling around her (positioned around waist). She (R997) said she (R997) was ready to go the bathroom "now'. I should have put on her call light and asked somebody else to bring the (mechanical stand lift) or found the (mechanical stand lift) first. I should have stayed with her (R997). I told her (R997) not to get up. I told her I had to go get the machine to lift her onto the toilet. I left her sitting at the bathroom doorway and went to get the (mechanical stand lift). I can see where she thought she could go on her own. We always take her right away once we have her outside the bathroom door and get the sling (mechanical stand lift) on her. The (mechanical stand lift) down here (R997's hallway) was being used. I had to wait until it was available or go get the one on the next hall. I was probably gone, at most ten minutes. When I returned. (R997) was on the floor between the toilet and the wall. Her pants were down, and she had tried to transfer herself. She had urinated all over the floor and her wheelchair seat was really wet. I shouldn't have left her, she has dementia. I should have left her watching tv (television), gotten the

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(mechanical stand lift) before I moved her in front of the bathroom door. I think placing the sling and leaving her outside the bathroom door, made her think it was time to go, so she went by herself. If I were to do it over again, I would have left (R997) across the room watching tv when she said she needed to go to the bathroom and come back to her when I realized the (mechanical stand lift) was being used and not outside her room. I would put the call light on to let someone know I was waiting (for the mechanical stand lift)."

On 1/19/24 at 9:40 am V2 (Director of Nursing) confirmed the incident report above regarding R997's fall 01/12/24 documents R997's call light was in reach is a documentation error. The call light would not be able to reach R997's wheelchair because R997's wheelchair was positioned at R997's bathroom door and the call light is attached at the wall outlet at the foot of R997 bed fifteen feet away.

The facility policy "Incidents and Accidents Reporting" dated 7/18/2016 documents the following:
POLICY STATEMENT
Accidents or incidents occurring in (the facility name) or involving (the facility) shall be investigated and reported to the Director of Nursing or his/her designee.
Numerous and varied accident hazards exist in our everyday life. Not all accidents are avoidable. The condition of some or our residents increases their vulnerability to hazards in the resident environment and can result in life threatening injuries.
We are responsible to provide care to our residents in a manner that helps promote quality of life. This includes respecting residents' right to privacy, dignity and self-determination, and their

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right to make choices about significant aspects of their life in the facility.
For a variety of reasons, residents are exposed to some potential for harm. Although hazards should not be ignored, there are varying degrees of potential for harm. It is reasonable to accept some risks as a trade-off for the potential benefits, such as maintaining dignity, self-determination, and control over one's daily life.
Staff are encouraged and expected to report incidents/accidents immediately.
DEFINITIONS
Accident: Refers to any unexpected or unintentional incident, which may result in injury or illness to a resident.
Assistance Device/Assistive Device: Refers to any item (i.e. handrails, transfer lifts, canes, etc.) that are used by, or in the care of a resident to promote, supplement, or enhance the resident's function and/or safety.
Fall: Refers to unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force. An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.
Hazards: Refers to elements of the resident environment that have the potential to cause injury or illness.
Resident Environment: Includes the physical surroundings to which the resident has access.
Risk: Refers to any external factor or characteristic of an individual resident that influences the likelihood of an accident.
Supervision: Refers to an intervention and means of mitigating the risk of an accident.

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"B"

Three of Three

300.1210b)

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.

These requirements were not met as evidenced by:

III. Based on observation, interview and record review the facility failed to ensure a resident (R998), dignity was maintained while dining. R998 is one of three residents reviewed for dignity on the sample list of three.

Findings include:

R998's Diagnoses Sheet updated 10/01/23 documents the following diagnoses: Unspecified Lack of Coordination, Dementia in Other Diseases Classified Elsewhere, Without Behavioral Disturbance, Mood Disturbance Anxiety and Parkinsonism.

R998's Minimum Data Set dated 11/21/23 documents R998 has a Brief Interview of Mental Status score of four out of a possible 15 which

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indicates severe cognitive impairment.

R998's Plan of Care dated 1/18/24 documents the following:
"Help (R998) eat & drink at mealtimes, (R998) needs time to swallow."

On 1/16/24 at 11:05 am V9 (Certified Nursing Assistant/CNA) was very tall, standing up feeding in front R998's semi-reclined in a geriatric chair. V9 continued to feed R998 standing up for eight minutes.

On 1/16/23 at 11:15 V9 stated "(R998's) wheeled geriatric -chair is a little too high for me. I get very uncomfortable when I set down to feed him. That is why I have to stand up to feed him."

On 1/16/23 at 1:30 pm V2 (Director of Nursing) stated "(V9) was (R998's) CNA today. (V9) will have to be educated. This is a dignity issue. No one should stand over a resident to feed them."

The facility (Private Company) staff education protocol dated 2022 documents the following:

Safeguarding Resident Rights in Nursing Facilities
Section 1: Introduction
About This Course
The government has created policies ensuring that all people have certain rights, protections, and freedoms. These rights, protections, and freedoms support people to live their life based on their own values, priorities, needs, and goals. Every person, regardless of their age, health, gender, race, or ability, has the same rights. You have the ethical and legal responsibility to protect the rights of the people your organization takes care of. This course discusses residents ' rights

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as well as how you can support and protect these rights for all of the individuals in your organization.
The goal of this course is to educate general staff in long-term care and assisted living facilities on resident rights.
A large portion of the information in this module was sourced from Appendix PP of the State Operations Manual last updated in 2017 as published by the Centers for Medicare & Medicaid Services."
The same protocol documents:
"Dignity
To protect someone's dignity you want to ensure that their self-esteem and self-worth are supported. Continence care is one area that is sensitive to respecting someone ' s dignity. Imagine the effect on your self-esteem if you needed someone to clean you up after a bowel movement.
There are consequences for everyone when dignity is not maintained. Facilities tend to have a higher staff turnover. Residents feel vulnerable, degraded, and embarrassed and they may resist care.
There are some steps to take to support a person's dignity, including:
Ask for permission to provide care.
Respect their grooming and dressing preferences.
Safely promote independence with activities of daily living.
Show respect for their private space and property.
Offer choices in daily activities.
Help them be involved with friends and family.
Learn their personal history.
There are other steps you can take to make sure that you are protecting a resident's dignity,

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S9999	Continued From page 12 including: Use a catheter drainage bag cover. Use napkins as a clothing protector. Sit when assisting the resident with eating rather than standing. Talk with the resident when assisting with care rather than talking to other staff. In addition to not laughing at behaviors, also avoid words that can be demeaning. For example, if someone requires assistance with eating, avoid calling them a "feeder." "C"	S9999		