

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008130	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/16/2020
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NAME OF PROVIDER OR SUPPLIER GENERATIONS AT ROCK ISLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 2545 24TH STREET ROCK ISLAND, IL 61201
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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
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S 000	<p>Initial Comments</p> <p>Complaint Investigation</p> <p>2022880/IL122014 2023965/IL123148 2025841/IL124770 2025819/IL125115 2025960/IL125271 2026239/IL125564 2026266/IL125593 2026609/IL126018 2026781/IL126222 2026857/IL126309 2026877/IL126328 2027065/IL126553</p> <p>Facility Reported Incident of 6-7-20/IL125890</p>	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>(Violation 1 of 3)</p> <p>300.610a) 300.1210b) 300.1210d)2) 300.1210d)3) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>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:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>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. Section 300.3240 Abuse and Neglect</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, interview and record review the facility neglected to provide skin assessments and physician ordered treatments for five (R2, R6, R40, R62, R95) of eight residents reviewed for wound care in the sample of 95. This failure resulted in impaired healing and worsening skin conditions for residents with known wounds. The facility also neglected to provide timely lifting assistance for R87 after a fall and failed to provide appropriate lifting equipment for R40 resulting in a missed dialysis appointment for R40 on 8/13/2020. The facility neglected to provide skin care to R40 causing R40 to refuse dialysis in 09/01/2020 because of extreme pain. These systematic failures resulted in worsening wounds, increased pain, and missed dialysis.</p> <p>Findings include:</p> <p>The facility's undated Abuse Prevention Program, documents "Neglect means the failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident."</p> <p>The facility policy for Wound Care, dated 5/17, documents "Follow physician's orders for wound care. Documentation of wound care must be completed each time the treatment is done. This documentation will be done on the Treatment Administration Record (TAR). Current wound status must be documented no less than once a</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>week. Facilities using (Electronic Health Records) EHR will complete a weekly treatment (Non-Pressure Ulcer) documentation observation. Wound changes and other pertinent observations must be documented in the Nurses Notes as they occur."</p> <p>Medical-Surgical Nursing Clinical reasoning in Patient Care, LeMone, Burke, Bauldoff and Gubrud, 6th Edition 2015; documents, "The skin and its accessory structures (the integumentary system) enclose and cover the body, providing protection by serving as a barrier between the internal and external environments."</p> <p>1. On 9/1/2020 at 12:00PM R40 stated, "I missed dialysis a couple of weeks ago because there wasn't a sling to get me out of bed. I had to go to the hospital for dialysis. I have trouble sometimes getting out of bed because there isn't always enough staff to get me up either. I have only had three showers since I was admitted in December and I do not think my hair has been washed for a couple of months. They do not have any caps to wash my hair with like they do in the hospital. I have two treatments. One on my right hip and the other towards the groin. I got bandage put on yesterday. I am lucky to have my treatment done once a month. No one ever shows up to do it on the weekend."</p> <p>On 9/1/2020 at 11:30AM V32 (Registered Nurse/RN/Dialysis RN) stated, "The nursing home did not have sling to transfer R40 out of bed on Friday 8/14/2020 so V29 (Nephrologist) sent her to the hospital for dialysis. She could not go through the weekend without dialysis treatment. We do try to accommodate the lack of staff time or equipment if the residents cannot get in at their time for dialysis. We cannot do anything</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>if they cannot get them out of bed."</p> <p>On 9/2/2020 at 1:00p.m. V29 stated, "(R40) had to be sent to the hospital for dialysis because the facility did not have sling to transfer (R40) out of bed for dialysis. It was Friday and she could not go the entire weekend without dialysis. It could be very detrimental to her health if she had not been hospitalized."</p> <p>On 9/1/2020 at 1:40PM V3 (Licensed Practical Nurse/LPN/Treatment Nurse) stated, "(R40) went to the hospital and returned on 8/22/2020. The treatment order did not get 'pulled forward' (entered into R40's medical record) so there was not a treatment until yesterday (08/31/2020, nine days later). Now she has an open area on her right abdominal apron too."</p> <p>On 9/1/2020 at 1:45p.m. V3 (Certified Nurse Aide/CNA) and V10 (CNA) assisted R40 to roll on to her left side. R40's right hip and back of her right thigh had multiple round and linear shaped open areas ranging from pinpoint to larger than a quarter in diameter with defined borders, bright red in color with scant bleeding. This surveyor counted 12+ wounds on the back of R40's thigh and another 4+ wounds on her hip at beginning of the crease in her belly fold and under her "apron" belly flap. V18 (LPN) verified the presence of the wounds then cleaned the areas. R40 started to complain and wanted to be placed on her back to rest. V18 and V10 lifted R40's belly apron further to perform a treatment to the center lower abdomen. R40's lower abdomen was observed to be covered with a malodorous thick, white, mucous substance and more open wounds. V3 and V10 then assisted R40 to her left side. As they repositioned R40 on her right side, there was dried stool down the back of R40's left leg. R40</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>was observed to have draining blood blister on the upper right quadrant of her abdomen and open areas in the creases of the outer aspect of her left thigh and abdominal fold verified by V3. During the treatment R40 stated to V3, "I have so much pain in that sore (motioning to her left lower belly) that I didn't go to dialysis this morning."</p> <p>On 9/1/2020 at 1:20p.m. V18 (Licensed Practical Nurse/LPN/Treatment Nurse) verified the two treatment orders for R40 to be completed: Left lower apron abdomen - cleanse with wound cleanser, place a 6x10 Optilock (moisture absorbing dressing) x2 lengthwise to absorb weeping, change daily, start date 8/31/2020. The second order was to the right lower aspect of the lower abdomen: cleanse with soap and water, pat dry, apply Optifoam (adhesive dressing with an absorbent center), 4x4 change daily, start date 8/31/2020. There were no other treatment orders present for the other wounds.</p> <p>On 9/1/2020 at 2:15p.m. V3 stated, "All those open areas were new. I did not know about them. And that white stuff under (R40's) belly is just 'funk' from not having a shower. She refuses them all the time."</p> <p>R40's June, July and August shower sheets were reviewed. R40 has not received a shower in those months. R40's Activity of Daily Living documentation does not document R40 as having a daily bed bath for cleanliness.</p> <p>The last Skin Management report provided by the facility dated 8/19/2020, did not have a readmission skin report for (R40) upon return from her 8/22/2020 hospitalization. On 8/22/2020 V31 completed an admission assessment that stated R40's pressure wounds were the same as</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>they were before her hospitalization. No wound measurements, stages or locations were noted on the assessment.</p> <p>On 9/1/2020 at 2:40PM V3 stated, "(R40's) 8/22/2020 readmission skin assessment did not get done that day because it was a Saturday or Sunday, because I don't work on Sundays. Mondays and Tuesdays I do the COVID testing so I did not do treatments on those days." The last Skin Management report provided was 8/19/2020, not a readmission report post the 8/22/2020 hospitalization. On 8/22/2020 V31 (LPN) completed an admission assessment that stated R40's pressure wounds were the same as they were before her hospitalization. No wound measurement or location was noted on the assessment.</p> <p>On 9/2/2020 at 12:50 p.m.V30 (Dialysis Office Manager) verified R40 did refuse dialysis on 9/1/2020.</p> <p>The National Pressure Ulcer Advisory Panel (NPUAP) Clinical Practice Guideline Manual 2009 documents, "Skin Moisture: General measures, as well as urinary and fecal incontinence, emerge in epidemiological studies as factors associated with pressure ulcer development." "Failing to provide appropriate strategies when an individual has been identified to be at risk of pressure ulcer development is a failure in the duty of care owed by the health professional and can be determined as negligence." "It is important to note that skin damage from moisture is not pressure, but that presence of skin damage from moisture may increase the risk of ulceration."</p> <p>2. R95 was admitted to the facility on 8/7/2020 with daily wound care orders for a recent trans</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>metatarsal (toe) amputation on her right foot, cellulitis in her left lower leg, and an open area on her left heel. R95 discharged home on 8/21/2020. The admission skin assessment documents R95 had a pressure ulcer on her left heel, however no measurements of the wound were documented. There was no mention of the surgical site on this assessment.</p> <p>R95's Physician's Orders document treatment orders: Right lower extremity. Betadine swabs. Apply topically for wound paint to incision sites. Cover with 4x4's and Kerlix. Complete the treatment daily. The order date was 8/8/2020. The treatment for the left lower extremity dated 8/8/2020 is cleanse (the Wound) gently, dry and pack with a Dakin's solution soaked 4x4. Wrap with Kerlix and wrap with Ace Wrap.</p> <p>On 9/4/2020 at 10:30 a.m. R95 stated, "I can tell you that I did not get a shower during my stay at Generations. I was not offered one the entire time I was at the facility. No one was 'mean' to me, they just would not do anything for me. I could not get out of bed for breakfast until sometimes 11:00 a.m. I have Acid Reflux and cannot eat while I am lying in bed, so I missed breakfast on those days because I would not eat it. When I first got to the facility, I laid in bed for two days because they said the lift wasn't charged. Now, you and I both know it does not take two days to charge a lift. They just didn't want to get me out of bed. I even asked someone why they agreed to take me if they could not take care of me! The first three days, no one changed my dressing. They only changed it one time while I was there."</p> <p>On 9/4/2020 at 12:00p.m. V28 (Podiatrist) stated he had been treating (R95) and was continuing to treat her. V28 verified her treatments were to be</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>completed on a daily basis for both right and left feet. He stated on 8/18/2020 she came to the wound clinic with a dressing in place dated 8/10/2020.</p> <p>The facility was not able to provide the Treatment Administration Record for R95's stay at this facility. There was not a wound management or a Weekly Treatment (Non-pressure Ulcer) documentation observation completed for R95.</p> <p>3. R62's Physician Orders, dated 6/30/20, documents "Right Malleolus: Cleanse with wound cleanser, pat dry. Apply thin layer of Santyl to center slough area. Cover with Silicon 4 x 4 foam dressing. Change Monday, Wednesday, Friday and PRN (as needed)."</p> <p>On 9/1/20 at 12:20 pm R62's right malleous was covered with a foam dressing dated 8/26/20 with visible dark drainage underneath the dressing. The edges of the foam dressing were rolled up and not adhered to R62's foot. R62 stated he usually has to tell the staff when the dressing comes off, otherwise they change it every couple of weeks.</p> <p>R62's July 2020 TAR (Treatment Administration Record) documents Physician ordered wound treatments were not completed as ordered. The facility was initially unable to locate an August TAR for R62; however, on 9/11/20 the facility provided an August TAR which also documents Physician ordered wound treatments were not completed as ordered. R62's dressing was not changed on 8/28/20 or 8/31/20 per Physician order.</p> <p>R62's August TAR (Treatment Administration Record) documents V3 (LPN/Wound Nurse)</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>performed the treatment to R62's right lateral malleolus on 8/26/20. This same TAR does not document R62's treatment was completed on 8/28/20 or 8/31/20.</p> <p>There is not weekly wound documentation for R62's right malleolus wound and only sporadic Weekly Wound Tracking and Wound Management Notes between 6/3/20 through 8/26/20.</p> <p>A Wound Management note, dated 8/26/20 by V3, documents R62's right malleolus measurement at "0.8 cm (centimeters) x 1.2 cm x 0.2 cm," "moderate" amount of "seropurulent exudate," "unstageable" with "100% granulation," wound edge "attached to base," "dark purple or rusty discoloration." "Improving." There is no weekly wound documentation for R62's wounds between 6/30/20 and 8/26/30.</p> <p>On 8/27/20 at 10:38 am, V6 (RN) stated, "The wound nurse does the treatments, or we would. They don't tell us if the treatments were done or not."</p> <p>On 8/27/20 at 10:45 am, V7 (RN) stated, "We have a fulltime wound nurse, Monday through Friday who does the treatments, but they aren't getting done. No one tells us if the Wound Nurse did the treatments or not. We do them on the weekends if we can."</p> <p>On 8/31/20 at 2:20 pm, V19 (LPN) stated, "I do not do wound treatments when the treatment nurse is here. I am not sure if there are any days she doesn't do them, but I don't do them."</p> <p>On 8/31/20 at 2:25 pm, V17 (RN) stated, "I do the treatments if the Wound Nurse is out. I</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>understand the treatment nurse does all the treatments."</p> <p>On 8/31/20 at 2:30 pm, V37 (LPN) stated, "I orientated a new nurse for the facility today. No treatments were done today. There is a treatment nurse today. I work here frequently, and I have not done treatments for the last two months."</p> <p>On 9/1/20 at 1:05 pm, V43 (RN) stated, "Only one time has anyone ever told me that treatments weren't done and that I needed to do them, and the agency nurses tell us they don't do treatments."</p> <p>On 9/10/20 at 12:30 pm, V19 (LPN) stated, "I never get the chance to do treatments. The workload doesn't allow for time. I've told V2 (DON) that residents complain about their treatments not getting done and that therapy has complained of not being able to do therapy treatments due to resident wound dressing falling off. I can be off for three to four weekdays or weekends and come back and the treatments will still not be done."</p> <p>4. On 8/27/2020 at 10:45 a.m. R6 stated she does not receive her treatment as ordered. R6 pointed to a bag of dressings and wound care items on the floor. R6 stated, "Those are from the hospital. I keep them in my room so they (the nurses) do not have a chance to leave 'to get wound care supplies'. They say that and then do not come back. I have an abscess and it just got drained. They are supposed to keep an eye on it, but they don't check it much. I just tuck a pad in there if it starts leaking."</p> <p>On 8/27/2020 at 10:30AM V3 provided care to R6's wounds in her right groin. V3 pretreated the</p>	S9999		
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S9999	<p>Continued From page 11</p> <p>open areas at R6's request with "Lidocaine gel" from a jar of clear gel removed from the green hospital bag on the floor next to R6's bed. V3 then irrigated R6's wounds, packed with an iodoform gauze rope and then placed a large gauze pad over the areas. When V3 completed the treatment, she explained there was not an order for her to pretreat the open areas with the Lidocaine gel but she would get an order.</p> <p>R6's current treatment order documents: Cleanse with wound cleanser, pack wound to right groin with Iodoform daily and cover with an large gauze pad date 8/25/20. There is no order for Lidocaine gel to be administered to the open wounds.</p> <p>5. R2 was admitted to the facility on 3/22/2020. The admission documents from the previous facility document R2 was being treated with a wound vac after chemical burn after surgical intervention to her right buttock and thigh.</p> <p>R2's March Treatment Administration Record (TAR) documents two treatments dated 3/22/2020 which document to "Apply wound vac to right buttock hip area Monday, Wednesday, Friday" which was not documented as completed for the month of March. Another treatment is documented on the March MAR "Cleanse the right buttock and calf area with normal saline or wound cleanser, pat dry, apply collagen powder mixed with Gentamycin. Apply twice a week on Sunday and Thursday." This treatment was documented as completed one time on March 22.</p> <p>R2's 4/2/2020 Progress notes document the wound orders were changed due to her lack of compliance with the wound vac.</p> <p>R2's April treatment orders have a line drawn</p>	S9999		

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S9999	<p>Continued From page 12</p> <p>through both orders with a notation that states wet to dry dressing to right hip with no date on the order. There are no initials in the spaces allotted to note the treatment was completed during the month of April.</p> <p>R2's May TAR documents the ordered treatment dated 4/8/2020 to "Cleanse wound daily with wound cleanser. Apply wet to dry dressing with Dakins solution daily." This treatment order does not document which area of the body to perform the treatment but was documented as completed 15 days in April.</p> <p>R2's June MAR documents this same treatment was completed on June 1, 2, and 5, 2020</p> <p>R2's last wound assessment for the right calf was documented by V34 (Registered Nurse Treatment Nurse/RN/Tx). V34 assessed the wound as a Stage 3 pressure ulcer, not a burn as documented upon admission.</p> <p>R2's last wound assessment on her right buttock dated 6/10/2020 documented by V3 assessed the wound as a Stage 4 pressure ulcer and was not healed.</p> <p>R2 discharged (Against Medical Advice) on 6/15/2020.</p> <p>6. R87's Face Sheet documents R87 with the following diagnoses: Morbid (severe) obesity with alveolar hypoventilation, COPD (Chronic Obstructive Pulmonary Disease), Shortness of breath, CHF (Congestive Heart Failure), Dependence on supplemental oxygen, GOUT (Inflammatory arthritis), History of MI (heart attack), and Chronic kidney disease. R87's EHR documents R87's current weight on 8/4/20 at 433</p>	S9999		
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S9999	<p>Continued From page 13</p> <p>pounds.</p> <p>On 9/1/20 at 11:45 am, R87 stated on 8/22/20 he rolled out of bed onto the floor at 4:50 am and laid there until day shift came in. R87 stated he yelled for help and R70, his roommate, turned on the call light to call for help. R87 stated "about an hour later" V19 (LPN) came to his door, made a rude comment, and walked away. R87 stated R70 called 911 and when 911 called back V19 told them not to come to the facility. R87 stated the fire department came at 6:45 am and helped the day shift get him up off the floor at 7:00 am. R87 stated no one, including V19, ever checked him for injuries and he was on the floor for over two hours.</p> <p>On 9/4/20 at 11:00 am, R70 stated on Saturday, 8/22/20, about 5:00 am, R87 fell out of bed and stated he (R70) put his call light on to call for help for (R87) and a hour or so later V19 came to the door and said "I don't know what you expect me to do." R87 stated "If you see someone lying on the floor you help them or call for help." R70 stated V19 left and never came back. R70 stated he called 911 to get some help but no one came until about 7:00 am. "I felt really bad for him because I couldn't help him."</p> <p>R87's Progress Notes, documented as a late entry on 8/23/20 at 12:10 pm regarding R1's fall on 8/22/20, documents R1's fall at 5:10 am. The facility Fall Report documents R1's fall occurred at 5:10 am. There is no timeline of events documented by V19 for R87's fall.</p> <p>On 9/10/20 at 12:30 pm, V19 stated, "We generally only have one nurse and one CNA (Certified Nursing Assistant) on each floor during the night. The night (R87) fell I only had one CNA</p>	S9999		
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S9999	<p>Continued From page 14</p> <p>on the fourth floor with me. There was a TNA (Temporary Nurse Aid) working with V31 (LPN) on the third floor. I have talked to V2 numerous times and told her I do not feel comfortable working with so little staff. That night we didn't have a sling to fit R87, and we could not leave the floor to go to the basement laundry area to retrieve the proper fitting mechanical lift sling for R87 due to not enough staff to cover the floor. We had to wait until day shift came and called the Fire Department to get R87 off the floor."</p> <p>On 9/1/20 at 12:05 pm, V9 stated, "(R87) fell on third shift around five in the morning and they waited until we got here on day shift so someone could go to laundry and find a bariatric sling to use with the mechanical lift. It was after seven a.m. before we finally got him up off the floor."</p> <p style="text-align: center;">(B)</p> <p>(Violation 2 of 3)</p> <p>300.610a) 300.1210b) 300.1210d)2) 300.1210d)3) 300.1630d) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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</p>	S9999		
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S9999	<p>Continued From page 15</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>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:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>Section 300.1630 Administration of Medication</p>	S9999		
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S9999	<p>Continued From page 16</p> <p>d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on observation, interview and record review the facility neglected to provide skin assessments and physician ordered treatments for one (R1) of eight residents reviewed for wound care in the sample of 95. This failure resulted in impaired healing and worsening skin conditions for R1 with known wounds. The facility failure also resulted in R1 being hospitalized and undergoing a right below the knee amputation.</p> <p>Findings include:</p> <p>The facility's undated Abuse Prevention Program, documents "Neglect means the failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident."</p> <p>The facility policy for Wound Care, dated 5/17, documents "Follow physician's orders for wound care. Documentation of wound care must be completed each time the treatment is done. This</p>	S9999		

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S9999	<p>Continued From page 17</p> <p>documentation will be done on the Treatment Administration Record (TAR). Current wound status must be documented no less than once a week. Facilities using (Electronic Health Records) EHR will complete a weekly treatment (Non-Pressure Ulcer) documentation observation. Wound changes and other pertinent observations must be documented in the Nurses Notes as they occur."</p> <p>Medical-Surgical Nursing Clinical reasoning in Patient Care, LeMone, Burke, Bauldoff and Gubrud, 6th Edition 2015; documents, "The skin and its accessory structures (the integumentary system) enclose and cover the body, providing protection by serving as a barrier between the internal and external environments."</p> <p>On 8/28/20 at 4:29 pm, R1 stated she went to the facility for wound care and dialysis and her right heel wound only got worse. R1 stated she was supposed to have a follow up with a podiatrist when she admitted to the facility in April and that did not happen until August. R1 stated her wound treatments were not done, she did not get a supplement the dietician tried to order for her for four months and did not receive the antibiotics like she was supposed to. R1 stated even when she asked for the treatments to be done, they would tell her they would tell the Wound Nurse, they didn't have the supplies to do the treatment, or would tell the next shift nurse. R1 stated V3 (Licensed Practical Nurse/Wound Nurse) only looked at her feet "three or four times" during her stay and when she asked V3 how it looked, V3 would say "looking good" or "just fine." R1 stated if they would have changed her dressing or "even looked at it, they would have seen the changes." R1 stated she tried to tell the staff and the doctor that her wound was getting worse and did talk</p>	S9999		
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S9999	<p>Continued From page 18</p> <p>with the podiatrist at the hospital who told her if her wound got any worse she would most likely have her leg amputated. R1 stated she is currently in the hospital and having her right lower leg amputated tomorrow morning on 8/30/20.</p> <p>R1's Face Sheet documents R1 was admitted to the facility on 4/2/20 with diabetic foot ulcers to her right and left heels and right ankle. The Admission Assessment also documents R1 with rash and skin disruption to R1's abdominal fold and admitted with a PICC (Peripherally Inserted Central Catheter) line.</p> <p>No wound measurements were obtained until 4/13/20. R1's EHR documents R1 was not seen by facility wound nurse until 4/13/20, was not seen until 6/30/20 by wound consultant services, and not seen by podiatrist until 8/18/20.</p> <p>Hospital Admission Records for R1, dated 4/2/20, document "Bilateral feet ulcers: Not infected as per podiatry. Outpatient follow up with podiatry recommended." The Physician Order was to cleanse bilateral heels with Dakins solution, apply SSD (Silver Sulfadiazine), cover with non adherent pad and wrap with gauze three times a week, on Monday, Wednesday, and Friday. This POS also documents Nystatin to be applied topically once a day.</p> <p>R1's TAR's, dated April through July 2020, include documentation of facility treatment for R1's right heel wound as not being completed.</p> <p>The TAR (Treatment Administration Record) for R1 documents R1's wound treatment was not completed on 4/3/20, 4/6/20, or 4/10/20, was done twice on 5/5/20 and 5/17/20, and was done four times on 6/1/20, 6/5/20, and 6/12/20. This treatment order was discontinued on 6/19/20,</p>	S9999		
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S9999	<p>Continued From page 19</p> <p>however was done again on 6/23/20. This TAR also documents that Nystatin was not applied during the months of April, May or June.</p> <p>Hospital Record for R1, dated 6/19/20, documents treatment "Plan - use silver AG and a Mepelex (dressing) to right calcaneus (heel) for protection" and to "refer to wound clinic for consult for right heel diabetic foot ulcer." R1's June and July TAR's were not changed to reflect this Physician Order.</p> <p>The POS for R1, dated 6/30/20, documents treatment for right heel to "Cleanse with wound cleanser/pat dry. Apply thin layer of Santyl to necrotic center. Apply collagen sprinkles mixed with scant amount of water to make paste and apply to granulated tissue. Cover with soft 6x6 silicon foam dressing. Change Monday, Wednesday, Friday and PRN (as needed)" and to "Apply skin prep to left heel daily."</p> <p>The TAR for R1, dated 6/1/20 through 6/30/20 does not include the 6/30/20 treatment orders or document that they were completed. The TAR dated 7/1/20 through 7/31/20 documents the treatment was not completed on 7/8/20, 7/17/20, 7/20/20, or 7/24/20. This same TAR documents R1's left heel treatment was not completed on 7/4/20, 7/5/20, 7/16/20 through 7/21/20, and 7/23/20 through 7/31/20. The facility was unable to locate or provide an August TAR for R1.</p> <p>The POS for R1, dated 6/19/20, documents Nystatin to be applied topically twice a day.</p> <p>The TAR for R1, dated 6/19/20 through 6/30 documents Nystatin treatment was not completed. The TAR for 7/1/20 through 7/31/20 documents Nystatin was not applied on 7/1/20,</p>	S9999		
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S9999	<p>Continued From page 20</p> <p>7/3/20 in am, 7/4/20 through 7/6/20, 7/7/20 in pm and facility was unable to provide a treatment record for the month of August 2020.</p> <p>R1's EHR documents the facility Registered Dietician (RD) saw R1 and made recommendations for R1 to receive 30ml (milliliters) of a liquid protein supplement on 4/8/20, 5/6/20, and 6/3/20. These dietary recommendations were signed off as orders by V8 (Nurse Practitioner/NP) and not processed until 7/6/20, was discontinued on 7/26/20 and reordered on 8/7/20.</p> <p>Hospital Record dated 7/28/20, documents right heel MRI (Magnetic Resonance Imaging) and biopsy were completed with a suspicion of Osteomyelitis and V27 (Doctor of Podiatric Medicine) following with plan to debride (surgical removal of devitalized tissue). "Plan: Patient is at a high risk for limb loss. Due to patients PVD (peripheral vascular disease) patient will require intervention for improvement of her vascular flow to her right lower extremities. If this wound further breaks down, she will most likely require a below the knee amputation."</p> <p>On 8/3/20, V8 (Nurse Practitioner) documented after R1's 7/28/20 hospitalization, a referral for R1 to see a Vascular Surgeon.</p> <p>On 8/18/20 V27 documented (R1) stated the facility has not been doing her dressing changes "and she is afraid that her leg has gotten worse due to this...(R1) is concerned about losing her leg. (R1) became very emotional during the visit. (R1) is to continue betadine dressing changes daily with assistance from nursing staff at (the facility). She states they have not been doing this...A referral will be placed for a consultation</p>	S9999		
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S9999	<p>Continued From page 21</p> <p>with a vascular surgeon." R1 has no TAR to reflect this Physician Ordered treatment.</p> <p>On 9/4/20 at 12:03 pm, V27 stated on 8/18/20 he did order daily Betadine dressing changes to R1's right heel to keep the wound bed dry and the "treatment certainly needs to be done." There is no August TAR for R1.</p> <p>V3 (LPN/Wound Nurse) confirmed that R1 admitted to the facility with an order for a podiatrist referral; however, R1 was not seen by a Podiatrist until her hospitalization in July. V3 also stated R1 does not have an August TAR and that R1's wound treatment ended up on R1's August MAR (Medication Administration Record). The only treatment documented on R1's MAR is dated 8/1/20 and is Dakins' Solution topically once a day every other day, however, does not list where this solution is to be applied and documents this treatment was not completed per order. R1's TAR, dated June through August 2020, documents treatment not completed as Physician Ordered. V3 stated, "There is no way to know that R1's wound treatments were done because they were not signed off that they were done. The nurses have been in-serviced and should be signing off that they completed the treatments. Back to Nursing 101; not signed out, wasn't done."</p> <p>On 8/27/20 at 10:45 am, V7 (RN) stated, "(R1) had osteomyelitis in her right foot wound and her treatment wasn't getting done."</p> <p>V8 (NP) documented on R1 in the Resident Progress Notes on 4/3/20, 4/9/20, 5/14/20, 6/3/20, 6/11/20, 6/14/20, 6/17/20, 6/22/20, 7/1/20, 7/6/20, 7/21/20, and 8/17/20. The only note that mentions R1's wound is from admission note on 4/3/20 that documents, "(R1) with open wounds</p>	S9999		
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S9999	<p>Continued From page 22</p> <p>on bilateral feet with bandages in place." The note, dated 8/17/20, documents what procedures were completed for R1's lower extremities while R1 was in the hospital and documents V27's referral for a vascular surgeon consult.</p> <p>On 8/27/20 at 10:50 am, V8 (NP) stated she did not see R1's right foot wound while R1 was residing in the facility. V8 stated, "V3 (LPN/Wound Nurse) was responsible to do (R1's) treatments and the nurses were to do them when (V3) was not in the facility."</p> <p>On 9/9/20 at 2:06 pm, V3 (LPN/Wound Nurse) stated she was hired in March 2020 to work as the facility wound nurse. R3 stated she worked as a floor nurse until 3/23/20 and was off until 4/13/20 for medical reason. V3 stated when she returned, she worked the first five weeks as a floor nurse and in May the DON walked out and she was pulled from the floor to assist with DON duties and is still doing this. V3 stated she has also been doing weekly testing on Mondays and Tuesdays which only leaves her Wednesday through Friday to work with wounds. V3 confirmed this is why she is unable to do all the wound treatments, why there is not weekly wound documentation done every week, and why the facility just hired a new wound nurse. V3 also stated she does not know why the RD's recommendations for R1 to receive the oral protein supplement for wound healing was not addressed or ordered in April, May, or June but was ordered in July. V3 stated R1 was ordered antibiotics in August for Osteomyelitis for her right heel wound and does not know if the medications were administered or not due to the Medication Administration Record (MAR) not being signed off as given and the Vancomycin was not listed on R1's MAR.</p>	S9999		
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S9999	<p>Continued From page 23</p> <p>There is sporadic Weekly Wound Tracking and Wound Management Notes between 6/3/20 through 8/19/20, not weekly.</p> <p>The POS for R1, dated 4/13/20, documents "PICC line dressing change ...measure arm circumference and catheter length, change caps with dressing change once a day every seven days." R1's PICC line order was discontinued on 6/19/20.</p> <p>The TAR for R1, dated 4/1/20 through 4/30/20 does not include the treatment for R1's PICC line or that it was completed. The TAR, dated 5/1/20 through 5/30/20, 6/1/20 through 6/30/20, and 7/1/20 through 7/31/20 does not document treatment was ever completed. R1's PICC line was discontinued on TAR on 7/6/20.</p> <p>On 8/31/20 at 11:34 am, V2 (Director of Nursing/DON) stated (R1) only saw V27 one time after her hospitalization in August. V2 stated, "We didn't end up getting the vascular consult for (R1) because she left against medical advice." V2 stated she could not find an August TAR for R1.</p> <p>On 8/28/20 at 4:29 pm, R1 stated, "They weren't taking care of me like they were supposed to, so I signed out AMA (Against Medical Advice) and left. I hope I can find a place closer to home that will take care of me better."</p> <p>R1's Progress Notes, dated 8/21/20, document R1 discharged home against medical advice.</p> <p>(A)</p>	S9999		
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S9999	<p>Continued From page 24 (Violation 3 of 3)</p> <p>300.610a) 300.1210b) 300.1210d)6) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>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:</p>	S9999		
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S9999	<p>Continued From page 25</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review the facility failed to provide supervision and failed to identify a possible injury of unknown origin for two (R9, R94) of six residents reviewed for falls in the sample of 95. These failures resulted in R9 not receiving increased supervision from a known prior fall intervention that resulted in R9 having another fall with a hip fracture, and R94 obtaining an intraventricular hemorrhage of bilateral ventricles of the brain resulting in R94 expiring.</p> <p>Findings include:</p> <p>The facility's Accident and Incident Report, Revised 04/2019, documents "1. Resident: c. Follow-up to be continued at minimum for 72 hours - which include vital signs, ROM (range of motion), skin abnormalities, responsiveness, general condition, changes observed in injury site, etc."</p> <p>Facility "Resident Census and Conditions of Residents" form, dated 8/28/20 by V1</p>	S9999		
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S9999	<p>Continued From page 26</p> <p>(Administrator) documents 86 residents reside in the facility. This form further documents 60 residents are occasionally or frequently incontinent, 56 require the assist of one or two staff for bathing and 26 are dependent, 75 require the assist of one or two staff for transferring and 8 are dependent, 81 require the assist of one or two staff for toilet use and 3 are dependent, and 69 require the assist of one or two staff for eating and 2 are dependent.</p> <p>"Facility Assessment," no date, documents "The facility has an average census of 85 with 43 residents on third floor and 42 residents on fourth floor. 48% have urinary incontinence, 39% have concerns with activities of daily living (ADLs), 37% have cognitive loss or dementia, 45% have falls, and 50% have concerns with nutrition. Facility has three bariatric residents that require additional staff to accomplish ADL care daily. Facility acuity is considered for staffing purposes in order to provide adequate ADL (Activities of Daily Living), skin, and medical care for each resident. Facility "Staffing Plan" checks daily staffing needs based on census, and skilled and non-skilled residents. Facility currently staffs slightly above these requirements to meet the acuity needs of facility residents. Licensed Nurses Providing Direct Care total number needed or average is one Nurse Practitioner and 17 Licensed Nurses. Nurse Aides total number needed or average is 37 CNAs (Certified Nurse Aides). Agency Staff - facility utilizes agency nurses and CNAs to meet daily staffing needs as needed. We review care needed by residents on each unit/floor to determine staff assigned. This is a combination of ADL needs, psychological needs, and any other special considerations to provide person centered care."</p>	S9999		
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S9999	<p>Continued From page 27</p> <p>Facility "Fall Log," no date, documents 20 falls for the Month of August 2020.</p> <p>1. The Face Sheet for R94, dated 2/17/20, documents R94 was admitted to the facility with the following diagnoses: Dementia without behavioral disturbance, Repeated falls, Physical injury and trauma - meniscus repair, Osteoarthritis, history of TIA (small stroke) and Cerebral infarction, Cognitive communication deficit, and need for assistance with personal care.</p> <p>The Admission Restorative Assessment for R94, dated 2/18/20, documents R94 requires supervision with bed mobility, limited assist with transfers and ambulation with a walker, balance unsteady but able to stabilize self, limited assist with bathing and dressing, supervision for personal hygiene and eating.</p> <p>R94's EHR (Electronic Health Record) documents R94 had falls on 2/19/20 at 4:30, on 2/26/20 at 2:45 am, on 3/24/20 at 2:50 pm, and on 6/7/20 at 11:30 pm.</p> <p>R94's Admission Fall Risk Assessment, dated 2/17/20, scored R94 as (17) "High Risk" for falls with history of "one or two falls" in the last 3 months with referrals recommended for Occupational Therapy/Physical Therapy (OT/PT). Fall Risk Assessments, dated 2/22/20 and 2/26/20 post falls document R94 scored (22) "High Risk" for falls.</p> <p>R94's Admission Care Plan documented "Assure the floor is free of glare, liquids, foreign objects. Keep bed in lowest position with brakes locked. Keep call light in reach at all times. Keep personal items and frequently used items within</p>	S9999		
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S9999	<p>Continued From page 28</p> <p>reach. Obtain PT consult as needed. Occupy resident with meaningful distractions. Orient resident when there has been new furniture placement or other changes in environment. Provide proper, well-maintained footwear. Provide resident and environment free of clutter. Provide toileting assistance before and after meals, at nighttime and as needed.</p> <p>The Fall Report for R94, dated 6/7/20, documents "This resident was noted to be in a left side lying position next to her bed with a large contusion on her left upper forehead. This resident stated, 'I fell out of bed.' The Root cause was determined to be related to resident's functional state. Fall Intervention - therapy to screen post fall."</p> <p>The local hospital CT Scan, dated 6/7/20, documents, "Diagnoses: Contusion of forehead, initial encounter and unwitnessed fall."</p> <p>R94's Fall Risk Assessment, dated 6/8/20, scored R94 as (19) "High Risk" for falls with history of "One or two falls" in last 3 months with referral for "Falls Prevention Program."</p> <p>R94's Care Plan was updated to include: "Therapy to screen post fall." R94's Care Plan does not include Falls Prevention Program.</p> <p>The Progress Notes for R94, dated 6/14/20, documents "Hematoma noted to left side of forehead, resident given Tylenol 500mg (milligrams) with relief noted." The Progress Note, dated 6/15/20 at 10:54 am, documents "Lump and discoloration to left forehead and discoloration to left jaw. Denies pain." The Progress Note dated 6/15/20 at 2:53 pm documents "Resident has slept most of the day. Will continue to monitor." The Progress Note,</p>	S9999		
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S9999	<p>Continued From page 29</p> <p>dated 6/17/20 at 12:15 pm, documents "Resident refused breakfast this morning, and refused to let nurse take VS (vital signs). Resident stated, Just leave me alone today, all I want is to sleep." The Progress Note, dated 6/19/20 at 1:55 pm, documents "This nurse communicated with NP due to concerns of large knot on left side of resident's head from fall on 6/7/20 and resident complaining of pain. NP (Nurse Practitioner) assessed and ordered for resident to be taken to ED." V8's (Nurse Practitioner/NP) Progress Note for R94, dated 6/19/20 at 8:17 pm, documents "Left forehead edema." The Progress Notes made by Nursing Staff are documented here. The Progress Note, dated 6/19/20 at 2:06 pm, documents "Received call from (Hospital) Nurse...CT (Computed Tomography) scan was done and patient does have bleed and she will contact family to inform them so they can decide on treatment."</p> <p>V8's Progress Note for R94, dated 6/19/20 at 8:20 pm, documents Nursing reports that patient has edema like knot of left side of forehead in area where she fell on 6/7/20. Pt's edema is the size of a golf ball. ED cleared patient on 6/7/20 after CT diagnosis of contusion of forehead.</p> <p>The local hospital discharge record documents "Final diagnoses: Intracranial hematoma with loss of consciousness, subsequent encounter Acute nonintractable headache, unspecified head type. Comfort measures only status.</p> <p>The local hospital CT Scan, dated 6/19/20, documents "Reason for Exam: Intermittent headache. Trauma." "Findings: A CT of head was performed without IV (intravenous) contrast. The cerebellum and supracellar cistern appear normal. Prominent scalp hematoma left frontal</p>	S9999		
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S9999	<p>Continued From page 30</p> <p>region. Acute intraventricular hemorrhage in both lateral ventricles. Focal hematoma in left lateral ventricle measuring 2 cm (centimeters). Diffuse atrophy with ventricular dilation. No obstructive hydrocephalus. Asymmetric low density adjacent to the right posterior temporal bone which may represent arachnoids cyst adjacent to the right cerebellar hemisphere. Chronic ischemic change in the basal ganglia regions and prominently seen in the pre-ventricular white matter. No subdural hemorrhage identified. No calvarial fracture. Postsurgical change in the right temporal bone." Final result documented as "Impression: 1. Prominent soft tissue hematoma left frontal region without underlying calvarial fracture. 2. Associated acute hemorrhage in both lateral ventricles left greater than right. No obstructive hydrocephalus. 3. No subdural hematoma or intraparenchymal hemorrhage identified. 4. Atrophy and chronic ischemic change.</p> <p>R94's Care Plan does not document any new interventions, Falls Prevention Program, or referrals for R94 other than for Hospice Services.</p> <p>V8's Progress Note for R94, dated 6/30/20 at 11:22 am, documents "Declining condition: Nursing concerned patient is declining. On 6/7/20 Pt was sent to ED due to fall and collision with roommate. Pt was sent back with dx (diagnosis) of contusion of forehead. A CT of cervical spine and head done June 10th. Pt was sent back to ED due to a prominent soft tissue hematoma to the left frontal region of forehead. Dx on return was acute hemorrhage or Intracranial hematoma with loss of consciousness in both lateral ventricles, left greater than right and acute intractable headache. Pt came back hospice. Pt has been declining ever since, pt now lays in bed, not alert, patient is not eating, no gross muscle</p>	S9999		
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S9999	<p>Continued From page 31</p> <p>activity. Breathing is still clear. No sign of impending death at this time."</p> <p>The Significant Change MDS (Minimum Data Set) Assessment for R94, dated 6/30/20, documents R94 cognitively impaired. This MDS documents R94 requires total assist with bed mobility, bathing, personal hygiene, and dressing and required extensive assistance with toileting. R94 was also frequently incontinent of bowel and bladder.</p> <p>On 9/1/20 at 12:40 pm, V8 stated R94 did have a fall on 6/7/20 and went to the local hospital for an evaluation, CT was done which was negative. On 6/19/20 V8 stated she sent R94 back to the local hospital because she had "swelling and looked like someone hit her in the head with a hockey puck" and the CT results came back that she had a subdural hemorrhage and returned to the facility on hospice services. V8 stated she is unaware of any other falls or incidents for R94.</p> <p>The Progress Note for R94, dated 7/1/20, documents R94 expired.</p> <p>2. R9's electronic medical record documents R9 was admitted to the facility on 6/1/20.</p> <p>R9's current care plan documents R9 was care planned on 6/14/20 for wandering at times and has impaired vision. R9 was also care planned on 6/1/20 for being at risk for falls related to dementia and difficulty in walking.</p> <p>R9's fall report, dated 7/3/20, documents R9 fell in the doorway of her bedroom and got a laceration and bump to her forehead. The root cause was the resident's confusion and the resolution was to increase rounding.</p>	S9999		

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S9999	<p>Continued From page 32</p> <p>R9's fall assessment, dated 7/3/20, documents R9 is a high risk for falls and staff is to perform 15 minute checks.</p> <p>R9's fall report, dated 8/26/20, documents a loud band was heard and R9 was found on the floor on top of a broken tray table. R9 was sent to the hospital to rule out a broken hip.</p> <p>R9's nurses notes by V13 (Registered Nurse/RN), dated 8/29/20 at 4:06pm, documents R9 was admitted to the facility from the local hospital with a right hip fracture.</p> <p>R9's progress notes by V8 dated 9/1/20 at 3:34pm documents "(R9) fell on 8/26/2020, patient was transported to ED (Emergency Department) for assessment and treatment if needed, and (R9) was dx (diagnosed) with a intertrochanteric fracture to the right hip."</p> <p>Facility was unable to provide any documentation on increased rounding or 15 minute checks for R9.</p> <p>On 8/27/20 at 10:45 am, V7 (Registered Nurse/RN) stated, "There are 42 people on this floor (4th floor). They only had one nurse and one CNA last night (8/26/20), we had a resident fall (R9), and we sent her to the hospital. Her call light was on, but no one answered it. We have multiple residents that require at least two assist and we do not have the staff for them. We've had more falls because we don't have enough staff to answer call lights and take care of residents like we need to. The Alzheimer's unit is up here too (4th floor). We can't do everything with one nurse and one CNA. Call lights will go off for hours. Just not enough staff to give the care."</p>	S9999		
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S9999	<p>Continued From page 33</p> <p>On 8/27/20 at 2:05pm, R43 stated, "I was in the room when (R9) fell. I put the call light on for (R9); she needed to go to the bathroom, she leaned against her table while waiting and she fell and broke her hip. They take a long time to answer call lights here because there is not enough of them. No one had been around here for quite a while, at least a half hour or so. There is never enough staff here, and you never see anybody to help you." R43's Minimum Data Set (MDS), dated 6/8/20, documents R43 is cognitively intact and requires supervision with one assist for transfers and personal hygiene. It further documents R43 is occasionally incontinent of bowel and bladder.</p> <p>On 9/4/20 at 10:20am, V28 (LPN) stated, "I was the nurse taking care of (R9) on 8/26/20 and I work second and third shifts. On 8/26/20 I heard a loud bang and I found (R9) sitting on her night stand/tray table next to her bed about 5pm. I did an assessment; I followed our protocol to get her up. She complained of her leg hurting so I called V8 to send her out to the hospital. The only staff working that night (on our floor) was one nurse and two CNA's (Certified Nurse Aides). (R9) is on the fourth floor, which has the Alzheimer's unit and other confused residents who do not need a secure unit. One of the nurse aides has to stay in the secured unit at all times, and one of the nurse aides is out on the regular unit. So that only left one nurse aid to care for R9 when she fell and to answer call lights. The 3rd floor is busier and we try to have four staff (two nurses and two CNAs). The residents on 3rd floor require more care, go out to appointments more, have insulins, and get more medications given. I am busy all the time I am there, and we have mostly agency nurses and CNAs. I don't get my breaks like I am supposed</p>	S9999		
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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008130	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/16/2020
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NAME OF PROVIDER OR SUPPLIER GENERATIONS AT ROCK ISLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 2545 24TH STREET ROCK ISLAND, IL 61201
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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
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Continued From page 34

to and the aides are not able to work together because one has to stay in the secured unit. I do not know how they get the residents' cares all met because I am busy passing medications and performing nursing duties so I do not have time to help them. I am working 50 hours this weekend where I am going in today (9/4/20) at 2pm. There was a time I worked 21 hours in a day because they needed me to work. We work with our own staff, agency nurses, and agency CNAs. These people deserve to get good care and have good nurses take care of them."

Facility "Resident Current Status Report," dated 8/26/20, documents 83 residents were in the building. Seventeen residents need skilled care and 66 need non-skilled care.

Staff time sheets provided by the facility, dated 8/26/20, documents a total of four nurses were assigned to work the afternoon shift from 2pm-10:30pm, and a total of six CNAs were scheduled for second shift from 2:30pm-11pm for the entire facility. There was also one CNA scheduled to work from 2:30pm-6pm.

S9999

(A)