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| S 000 | Initial Comments<br><br>Complaint Investigation<br>177109/IL 919976 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210c)<br>300.1210d)6)<br>300.1220b)2)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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 | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>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.<br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br>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:<br>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.<br><br>Section 300.1220 Supervision of Nursing Services<br>b)The DON shall supervise and oversee the nursing services of the facility, including:<br>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.<br><br>Section 300.3240 Abuse and Neglect<br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) | S9999 | | |

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| S9999 | Continued From page 2<br><br>These requirements were not met as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to provide supervision/monitoring for one resident, identified with unsafe smoking behaviors.<br>This failure resulted in the resident being unsupervised, falling on the patio, sustaining a fractured knee, and crawling to get help from staff in the middle of the night.<br>This applies to 1 of 3 residents (R2) reviewed for falls in the sample of 7 residents.<br><br>The findings include:<br><br>Review of R2's Face Sheet showed R2 is a 59 year old, who was admitted to the facility on October 05, 2005, with diagnoses including Mild Mental Retardation, Schizophrenia, and Type II Diabetic. R2 has a recent diagnoses of Acute Comminuted Displaced Fracture of Left Patella, which occurred from a fall on January 12, 2017.<br><br>Review of R2's Incident Report, dated January 12, 2017, showed: " 3 AM (R2) Location of Incident: Outside Patio (R2) complained of pain to his knee. (R2) was unable to ambulate, which was a change of condition. MD notified and sent to emergency room with x-ray revealing an acute comminuted and displaced fracture through the Patella of Left Knee. Type of Incident: Fall Type of Injury: Fracture "<br><br>Review of R2's Diagnostic Imaging Services, dated January 12, 2017, showed the following: "Exam: x ray Knee Bilateral History Knee Pain, fall on ice Impression: Comminuted, displaced | S9999 | | |

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| S9999 | Continued From page 3<br>fracture through the left patella with retraction of fragments "<br><br>Review of R2's nursing notes, dated January 12, 2017 at 3 AM, showed the following: "(R2) seen sitting on floor by door States, "I fell on my knees outside smoking patio "<br><br>Review of R2's Smoking Assessment, dated June 12, 2016 showed the following: "Comprehensive Evaluation Results, Unable to follow directions - Poor Safety Awareness - Behavior Evaluation Results .- Aggressive and disruptive - The Inter disciplinary Team determines the above named resident may smoke under the following condition: "Supervised "<br><br>Review of R2's care plan, dated June 20, 2015 continued to April 2017, showed R2 at risk because of behaviors and needing supervision. The nursing interventions were for R2 to be monitored while smoking to prevent R2 from picking up cigarette butts off the ground and smoking cigarettes until his fingers were burned.<br><br>Review of the facility's Smoking Policy, undated, showed the following: "Supervised Smoking Times 10 AM, 1:30 PM, 4 PM, 7 PM and assigned staff member will be observing residents while they smoke. Residents will be observed within close visual proximity. If staff do not physically want to be on the patio they can observe from the patio door but must be in place until the last smoker is finished "<br><br>Another area of concern in R2's care plan, dated August 12, 2015 continued to April 2017, showed: "Self care deficit-needs supervision and/or assistance to complete quality activities of daily living, as well as verbal cues. | S9999 | | |

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| S9999 | Continued From page 4<br><br>Alert and oriented residents were interviewed in their rooms. The residents reported that staff were not always available to assist residents who needed to be supervised in the area of the outside patio/courtyard used for smoking.<br><br>On March 01, 2017 at 3:36 PM, R6 was interviewed in his room. R6 said prior to R2's incident, we (residents) could go out into the courtyard and smoke anytime at night, because the patio door was unlocked, and staff were not always outside to supervise. R6 also complained that the night shift staff was not always helpful or available for residents.<br><br>R4 was interviewed on March 1, 2017 at 3 PM. R4 said before R2 fell, we (independent smokers) could go out and smoke anytime and staff did not always provide supervision during the smoking times to prevent R2 from picking up cigarette butts and smoking unsupervised. R4 said R2 would stand over you and beg for cigarettes. R4 stated staff did not provide R2 with the supervision he needed and made her think staff was unorganized.<br><br>R7 was interviewed on March 2, 2017 at 3:49 PM. R7 complained that staff did not always supervise residents who needed it at night or be readily available when help was needed. R7 stated sometimes the patio door to the courtyard was left unopened so residents could smoke and staff were not always there to supervise R2 from picking up butts.<br><br>On March 01, 2017 at 3:29 PM, R5 was interviewed in her room. R5 stated before the incident with R2, staff left the patio door open at night so the independent smoker could go out at | S9999 | | |

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anytime and smoke. R5 said sometimes staff was not present to supervise residents. R5 stated she is an independent smoker, but staff did not want R2 smoking outside by himself. R5 said R2 picks up butts and smokes until his fingers get nasty and black. R5 stated R2 is always begging for cigarettes, and she (R5) is tired of his behavior. R5 stated she was in the dining room talking with another guy at 2 or 2:30 AM the morning R2 fell on the patio. R5 said she could not sleep, so she was up talking to another resident in the day room. R5 stated staff were not present and were doing rounds. R5 said it was dark outside and she did not see what happened. But, R5 stated I saw R2 crawling into the building. R5 stated R2 could not stand, so I told him to do nothing and the other resident went to get the nurse (E8). R5 said E8 came and checked R2 out, and I learned R2 broke his knee cap.

E8 was interviewed on February 28, 2018 at 4 PM. E8 said she was the nurse on duty when R2 fell. E8 stated the patio door is locked at 10 PM, and then the door is opened at 1 AM, so the independent smokers can go out to smoke. E8 said the CNA's (Certified Nursing Aides) should monitor the residents while they are smoking to ensure they (residents) do not share cigarettes or fight. E8 stated R2 is an independent smoker and could go out that night of the incident and smoke independently. E8 said I think one of the CNA's told me R2 had fallen. E8 stated she found R2 on the floor by the patio door and saw R2's leg was not in the right position and I knew he (R2) had a fracture.

E16, CNA was interviewed on March 2, 2017 at 4:45 AM. E16 stated she (E16) was R2's CNA the night of R2's fell. E16 said she was doing rounds and was unaware of what happened to R2

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| S9999 | Continued From page 6<br>until another CNA told her R2 had fallen. E16 described R2 as alert, but sometimes wanders at night, R2 walk around but mainly sits in the dining room. E16 said I think R2 was one of the residents who would be out there when the door to the patio would be picked. E16 stated some of the residents would pick the lock to the patio door at night and go out to smoke unsupervised. E16 said I think R2 was one of the residents who would go outside when the door was picked. E16 stated I know the residents picked the lock because it (the door) would be locked, and all of a sudden the door would be unlocked and residents are outside on the patio smoking. E16 said this went on for awhile, the residents were told not to go out there, but a lot of the time residents would be out there smoking unsupervised. E16 stated the independent smokers had cigarettes, and the supervised smokers were not allowed to carry their own cigarettes, and residents with cigarettes were allowed to smoke. E16 said we use to have a list identifying the smokers needing supervision, but I have not seen that list in a long time.<br><br>Interview with E14, CNA on March 2, 2017 at 5:05 AM stated she was working the night R2 fell, but I have no idea what happened to him, because I was doing rounds. E14 said I heard someone say R2 fell. E14 said when I went to see what happened other staff members were assisting R2. E14 said the door should have been locked, but the residents were able to pick the lock and go out smoking during the night shift. E14 was unsure if R2 was an independent smoker on the night he fell, or up to the time of this interview on March 2, 2017. E14 stated if residents have cigarettes they can go out and smoke, and that is how we can tell if residents are independent smokers. | S9999 | | |

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| S9999 | Continued From page 7<br><br>E7 was the other nurse on duty the night R2 fell. E7 was interviewed at 11 AM on March 1, 2017. E7 said it was maintenance or another resident that told me R2 had fallen. E7 said when he got to the dining room R2 was on the floor by the patio door. E7 stated R2 told me he had fallen outside in the courtyard and crawled into the building. E7 said R2 had a coat on because of the outside temperature, but he could not recall how cold it was outside. E7 stated at the time of R2's fall the patio door was left opened to allow the independent smoker to go outside into the courtyard to smoke.<br><br>E4 is the nurse, who took care of R2 after he fell. E4 was interviewed on February 28, 2017 at 12:08 PM. E4 said R2 fell during the night shift and I took care of him on the day shift. E4 said R2 was an independent smoker because he could walk, but needs supervision now because he uses a wheel chair and cannot walk now. E4 said R2 may have fallen in the courtyard that night because resident use to pick the patio lock and the other residents would follow them outside to smoke. E4 stated R2 did not keep cigarettes on him, but residents share. E4 said I think the camera showed R2 tried to get up, but fell again. E4 stated he heard another resident shared a cigarette with R2 while he was on the ground then went into the facility to report the incident to the nurse. E4 said the patio door should have been locked and residents supervised that night because of the cold weather. E4 also said it was reported that R2 slipped on ice that night while in the courtyard.<br><br>E15, CNA who works the night shift was interviewed on March 2, 2017 at 8:46 AM. E15 stated we only have a few independent smokers, but she was unsure if R2 was one of the | S9999 | | |

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independent smokers. E15 said there use to be a note saying R2 was not allowed to smoke because R2 would shake the ash tray can for cigarette butts, but that note is gone. E15 said we were never told who is an independent smoker, but we know because we worked with the resident for a long time.

On March 1, 2017 E9, CNA stated that she usually worked evening and night shift. E9 stated that R2 would go out to smoke on the patio and would not listen. E9 said if R2 is not supervised he will go out with the independent smokers, get a cigarette from another resident, or pick up butts. E9 said when residents pick the lock; R2 would follow them outside to smoke and would not listen. E9 stated that the activity director was responsible for running the smoker program and letting us know who can smoke independently.

On March 1, 2017 at 2:08 PM E8, Activity Director said she's been responsible for the facility's smoking program for the last 9 years. E18 stated the smoking rules have always been the same for residents to have scheduled and supervised smoking breaks for the last 9 years, we just have not enforced it consistently. E8 said according to the facility's smoking policy staff should be monitoring the residents as they smoke on the patio, but when R2 fell, the residents were going out on the patio at night smoking unsupervised. E8 stated R2 needs to be supervised because R2 will wander at night on to the patio to smoke unsupervised with the independent smokers. E8 stated R2 always wants to smoke and will try to go into the courtyard and smoke with the independent smokers anytime he (R2) sees the (independent smokers go out).

On March 2, 2017 at 1:14 PM E20, PRSC

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(Psychiatric Rehab Service Counselor) stated that R2 used to be on my case load but is currently working with another PRSC. E20 stated I assessed R2 on June 12, 2016 to have deficits in self maintenance, community living, social and cognitive impairments. E20 said R2 sometimes is in his own world, needs cueing and supervision to maintain activities of daily living. E20 stated R2 is not a safe smoker because R2 will pick up butts, share cigarettes of others and smoke cigarettes till they burn and turn his finger tips black and brown. E20 said she talked to the nursing staff about this behavior because R2 is a diabetic and any injury to his skin or development of a wound would impact his health. E20 stated R2 is always trying to get outside on the patio to smoke without supervision with the independent smoker, and needs monitoring and supervision to manage this behavior.

E19, PRSC was interviewed on March 2, 2017 at 1:34 PM. E19 said R2 needs to be supervised and does not have the capabilities to safely smoke independently. E19 stated R2 has burned his fingers in the past from smoking and attempts to smoke unsupervised.

On March 3, 2017 Z1 (Psychiatrist for RS) stated that his (R2) PRSC would address and identify the interventions needed to monitor and supervise R2 while smoking, because they work with him daily.

During Daily Status Meetings on March 3, 2017 and March 7, 2017, the administrative staff (E1/administrator and E2/director of nursing) was informed of concerns that nursing staff were not providing consistent monitoring/supervision of R2 who wanders around the building at night with possible unsafe behaviors. E1 said he reviewed

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| S9999 | Continued From page 10<br>the video tape of R2's fall and said R2 slipped and was not smoking. E1 gave no explanation of possible reason R2 was outside so early in the morning. E1 stated he observed on the video tape there was no witness to R2's fall, nor did E1 identify any staff being present in the courtyard coming to assist R2 after he fell on the ground. E1 said the patio door to the courtyard was left unlocked for the residents who smoke independently. E1 also said that one of the residents may have picked the lock and that is how R2 may have gotten out to the patio. E1 did not provide any evidence or identify any method staff used to monitor/supervise R2 who had behaviors (such: as picking up cigarette butts off the ground, shaking ash can for butts, irritating peers by begging, taking, or sharing cigarettes with the independent smokers) on a cold winter morning.<br><br>(B) | S9999 | | |