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S 000	Initial Comments Complaint Investigation #1771347/IL92306 Federal Oversight and Support Survey Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide supervision and a safe environment for the following issues:

1) Failed to provide supervision and interventions to prevent falls for 4 residents (R1, R5, R6, and R26). R1 sustained an acute mild to moderately displaced intertrochanteric fracture of the proximal left femur.

2) Failed to provide a safe environment by leaving the beauty shop unlocked with unsecured oxygen tanks affecting two sampled residents (R21, R22) on the second floor.

3) Failed to keep disposable razors in a locked area away from resident access affecting two sampled residents (R5, R37) on the third floor.

4) Failed to keep a chemical and

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medications inaccessible for the following residents: (R5, R7-R10, R21, R22, R37)

5) Failed to provide a safe environment by using power strips to plug in durable medical equipment affecting 4 sampled residents (R3, R19, R38, R39).

This applies to 15 of 62 residents (R1, R3, R5, R6, R7, R8, R9, R10, R19, R21, R22, R26, R37, R38, R39) reviewed for falls and safety concerns in the sample of 62.

The findings include:

1. The facility face sheet dated March 14, 2017 shows R1 was admitted to the facility on January 31, 2017 and discharged on March 5, 2017. The face sheet shows R1 had multiple diagnoses including fractured right femur, COPD (chronic obstructive pulmonary disorder), heart disease, chronic kidney disease, chronic atrial fibrillation, heart failure, fall, chronic pain, low potassium, presence of cardiac defibrillator, dysphagia, abnormal gait and mobility, age-related cognitive decline, dementia and psychosis.

The MDS (Minimum Data Set) dated February 28, 2017 shows R1 had severe cognitive impairment, required extensive assistance with all ADLs (activities of daily living), and was frequently incontinent of bowel and bladder.

R1's fall risk assessment dated January 31, 2017 shows R1 was a high fall risk.

R1's care plan dated February 1, 2017 shows, "Problem: Resident at risk for falling R/T (related to) right femur fx. (fracture). Approaches included bilateral fall mats, chair alarm when out of bed, keep bed in lowest position with brakes

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locked, and observe frequently and place in supervised area when out of bed.

E16's (RN-Registered Nurse) progress note dated March 5, 2017 at 5:30 PM shows: "[R1] was found on floor mats next to bed. CNA (Certified Nursing Assistant) was going into room to assist resident to w/c (wheelchair) for dinner when resident was noted on floor. [R1] on floor guarding left hip. [R1] c/o (complained of) pain in hip area rated 7/10. Transferred from floor to bed with 3 assist complete body assessment completed. No open areas noted, no redness or swelling noted bed was in lowest position floor mats in place. [R1] stated he was trying to take himself to toilet. Wife notified, [Z3] (physician) notified, on call manager made aware, orders received to send to [local hospital] for evaluation."

Hospital records for R1 dated March 5, 2017 show, "Acute mild to moderately displaced intertrochanteric fracture of the proximal left femur."

On March 15, 2017 at 1:38 PM, Z3 (physician) said, "[R1's] left hip fracture was caused by the fall."

On March 15, 2017 at 2:52 PM, E2 (DON-Director of Nursing) said, "If a resident is a high fall risk, we put them on the fall prevention program (L.E.A.F. - Let's End All Falls). We put alarms in place, fall mats, resident room near the nurse's station and a low bed. If a resident is a high fall risk, the L.E.A.F. sheet, with interventions, gets posted in the residents room behind the closet door. We usually try to keep high fall risk residents busy with activities. I expect all residents in the facility to be monitored every 1-1/2 to 2 hours. If a resident has a care

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plan intervention that includes frequent monitoring, then my expectation would be to monitor the resident every 30 minutes to 1 hour. [R1's] room was at the end of the hall, farthest from the nursing station. There was no system in place to show R1 had been monitored every 30 minutes to 1 hour."

R1's undated L.E.A.F. sheet shows R1 was a fall risk, had a chair alarm, floor mats, bed in the low position and extensive assistance with transfers. The sheet did not show frequent monitoring as an intervention for R1.

2. R5's face sheet dated March 15, 2017 shows R5 was admitted to the facility in July 2016 with multiple diagnoses including dementia with behaviors, psychosis, anxiety, repeated falls, rheumatoid arthritis, right hip pain, repeated falls and muscle weakness.

R5's MDS dated December 20, 2016 shows R5 has severe cognitive impairment, requires extensive assistance with all ADLs, and is always incontinent of bowel and bladder.

R5's Fall Risk Assessment dated February 14, 2017 shows R5 is a high fall risk.

Nursing documentation shows the following: R5 slid from his wheelchair in his room on February 22, 2017. On March 1, 2017 R5 fell during self transfer to the toilet. On March 3, 2017 R5 lost his balance and fell during transfer to the wheelchair with the CNA.

R5's fall care plan dated July 12, 2016 shows: "Falls: [R5] is at risk for falling R/T (related to) impaired transfer balance, unsteady gait. Approaches: Place [non-slip rectangular mat] in

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wheelchair. Chair alarm when out of bed. Keep call light in reach at all times."

R5's undated L.E.A.F. care card shows R5 is a fall risk, requires a chair alarm, and non-skid rectangular mat in the wheelchair.

On March 14, 2017 at 8:32 AM, R5 was laying in bed. One end of the call light cord was tied to R5's bed rail. The other end was laying on the floor, not attached to the call light switch on the wall. R5 would not have been able to activate the call light system with the call cord disconnected from the wall.

On March 15, 2017 at 12:30 PM, R5 was being transported via wheelchair to the dining room by E12 (CNA). R5 did not have a chair alarm in place or the non-slip rectangular mat on the seat cushion of the wheelchair.

On March 15, 2017 at 12:30 PM, E1 (Administrator) said R5's non-slip mat should be on top of his wheelchair cushion when R5 is sitting in the wheelchair.

On March 15, 2017 at 2:52 PM, E2 (DON) said, "The non-skid rectangular mat is a sticky on both sides and should be put under [R5] when he is up in the wheelchair. When R5 is sitting up in the wheelchair he should also have a chair alarm in place. He is very impulsive."

3. R6's face sheet dated March 15, 2017 shows R6 was admitted to the facility in September 2015 with multiple diagnoses, including history of falls, altered mental status, Alzheimer's disease, anxiety, UTI (urinary tract infection), muscle weakness, psychosis and dementia.

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R6's MDS (Minimum Data Set) dated January 19, 2017 shows R6 has severe cognitive impairment, requires extensive assistance with toileting, hygiene and bathing, and is always incontinent of bowel and bladder.

R6's fall risk assessment dated January 25, 2017 shows R6 is a high fall risk.

Nursing documentation dated January 7, 2017 shows R6 fell "attempting to transfer self from wheelchair to dining room chair." On January 25, 2017, R6 was found on the floor in her room, with the bed alarm sounding, and on February 23, 2107, R6 was found on the floor with the alarm sounding.

On March 13, 2017 at 4:45 PM, R6 was sitting in the dining room. A chair alarm was in place. No light was blinking on the alarm to indicate the alarm was powered on. E15 (Activity Aid) lifted the alarm and said the alarm power switch was in the off position. E15 said the alarm should be turned on.

On March 23, 2017 at 10:15 AM, E1 (Administrator) said the facility does not have a policy regarding alarms, and CNAs should check the connection between the alarm and the alarm pad, and are responsible for ensuring the alarm is turned on and in place.

On March 13, 2017, during initial tour of the facility with E3 (Assistant Administrator), between 11:05 AM and 1:30 PM, the following safety concerns were identified:

4. The beauty shop door on the second floor was open. No residents were present in the beauty shop. Three oxygen tanks were standing just

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inside the doorway. Two of the three oxygen tanks were free-standing, not secured or in holders.

E3 said the oxygen tanks should not be stored in the beauty shop.

The facility's policy entitled, "Oxygen Fire Safety Precautions" dated February 2014 shows: "5. All oxygen cylinders must be stored in racks with chains, sturdy portable carts, or approved stands and never left free-standing or in any resident room or living area."

5. The unlocked shower room on the south hallway of the second floor had approximately one dozen disposable razors sitting on the counter.

6. Four residents had medications at their bedside.

R7 had a tube of Clotrimazole topical, antifungal ointment on his dresser. R7 stated, "The nurse gave me that medication this morning. I'm supposed to put it on my armpit."

R8 had an Advair diskus inhaler on his nightstand. On March 15, 2017 at 4:55 PM, R8 said, "The nurse left it on the table in the dining room the other day, so I brought the inhaler back to my room, two or three days ago. It has been sitting on my nightstand since then. I told the nurse it was there, but she left it there."

R9 had a Breo Ellipta inhaler at his bedside.

R10 had a tube of Betamethasone (steroid) cream on his nightstand.

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The March 2017 POS (physician order sheet) did not show orders for medications to be kept at the bedside or self-administered by R7-R10.

On March 15, 2017 at 5:30 PM, E1 (Administrator) and E2 (DON-Director of Nursing) said the facility did not have a system in place to ensure resident medications were kept secured in resident's rooms.

The facility's policy entitled, "Bedside Medication Storage" dated October 27, 2014 shows: "Bedside medication storage is permitted for residents who wish to self-administer medications, upon the written order of the prescriber and once self-administration skills have been assessed and deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team. Procedures: A. A written order for the bedside storage of medication is present in the resident's medical record."

7. The room shared by R9 and R22 had a bottle of rubbing alcohol on the dresser shared by the residents.

8. R26 was sitting in the activity room in a wheelchair. A chair alarm was connected to the back of her wheelchair, however, the alarm did not have a cord to connect the alarm to the resident. E15 (Activity Aid) said, "Restorative took the alarm off."

9. R3's air mattress on the bed was plugged into a power strip.

10. R19's tube feeding and oxygen were plugged into a 3-outlet adaptor located above R19's headboard.

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11. R38's bed and phone charger were plugged into a power strip.

12. R39's bed was plugged into a power strip.

The facility did not have a maintenance program or documentation to show the power strips were regularly monitored by E4 (Maintenance Director). On March 15, 2017 at 11:30 AM, E4 said, "A 3-outlet adaptor is is just like an extension cord. There is no problem using the adaptor in the resident's room." E4 did not have information regarding amperage of power strips.

The facility's policy entitled "Power Strips Requirement and Safety Policy" dated September 2014 shows: "Policy: To ensure al personnel are aware of fire safety regulations for the use of power strips in patient care rooms and patient care vicinity. Policy Specifications: ..Power strips may be used in a patient care vicinity, provided all of the following conditions are met as required by section: The sum of the ampacity of all appliances connected to the receptacles shall not exceed 75 percent of the ampacity of the flexible cord supplying the receptacles. ...The electrical and mechanical integrity of the assembly is regularly verified and documented through an ongoing maintenance program. ..Means are employed to ensure that additional devices or nonmedical equipment cannot be connected to the multiple outlet extension cord after leakage currents have been verified as safe. ...Resident rooms using line-operated patient-care related equipment in the patient care vicinity must comply with the NFPA 99 power strip requirement and may elect to utilize this categorical waiver.

13. On March 13, 2017 at 4:39 PM, a medication

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S9999	Continued From page 10 cart on the third floor was unlocked and a Spiriva inhaler was sitting on top of the unlocked medication cart. The unlocked drawers faced away from the resident's room. E9 (nurse) was inside a resident's room and was not in visual control of the medication cart. E9 exited the resident's room and said the medication cart should have been locked and medications locked inside when the cart was not in her visual control. The facility identified R21 and R22 as ambulatory residents with intermittent confusion residing on the second floor. The facility identified R5 and R37 as residents residing on the third floor with intermittent periods of confusion and mobile via wheelchair. (B)	S9999		