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| S 000 | Initial Comments<br><br>Complaint Investigations:<br><br>2297207/IL151029<br>2297090/IL150893<br>2297066/IL150859 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations (1 of 4):<br><br>300.610a)<br>300.1010h)<br>300.1210a)<br>300.1210b)<br>300.1210d)2)<br><br>Section 300.610 Resident Care Policies<br><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.<br><br>Section 300.1010 Medical Care Policies<br><br>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)<br><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 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><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, | S9999 | | |

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| S9999 | Continued From page 2<br>seven-day-a-week basis:<br><br>2) All treatments and procedures shall be administered as ordered by the physician.<br><br>These requirements were not met as evidenced by:<br><br>Based on interviews and records reviewed the facility failed to develop and implement an individualized care plan for a post surgical wound and failed to follow the surgeons discharge instructions to have resident seen 2 weeks post operatively. This affected 1 of 3 residents (R2) reviewed for care of surgical wound and discharge instructions. This failure resulted in R2's follow up appointment being delayed over 6 weeks. R2 presented to the follow up appointment with an infected surgical site and required emergency surgery.<br><br>Findings include:<br><br>Review of R2's faces sheet documents a 73 year old female admitted to the facility on 7/20/2022 with diagnoses that includes: Acquired Absence of left leg above the knee, Encounter for orthopedic aftercare following surgical amputation, Type 2 Diabetes Mellitus, Heart failure, Chronic Obstructive Pulmonary Disease, End stage renal disease, and Legal blindness.<br><br>R2's MDS section C dated 7/27/2022 documents R2 with a score of 11/15 which indicates moderate cognitive impairment. R2 MDS section C dated 7/7/2022 documents R2 required | S9999 | | |

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| S9999 | Continued From page 3<br>extensive to total dependence on staff for activities of daily living.<br><br>Review of R2's hospital discharge instructions dated 7/20/2022 documents R2 to follow up with V16 (Surgeon) in 2 weeks for suture removal.<br><br>R2's Wound evaluation forms dated 7/21/2022 document's R2 admitted with 3 wounds: left thigh surgical wound with 13 sutures and 23 staples, right lower back laceration, and Moisture associated Skin damage to sacrum.<br><br>Review of R2's full Care plan is absent of any skin or wound care plan.<br><br>Review of R2's Wound Care progress notes and found there to be 3 progress notes: one on the day after admission dated 7/21/2022 (by V44, Wound care nurse), one on 8/17/2022 (V44) when the Left AKA is noted to have multiple sites of dehiscence and eschar tissue and third wound care note is dated 8/30/2022 (by V13, Wound Care Nurse) that documents yellow exudate and Eschar tissue.<br><br>On 9/8/2022 at 10:40 AM V42 (Daughter of R2) stated, her mother's 8/3/2022 follow up appointment was canceled by the facility due to transportation issues and they never rescheduled it. V42 stated she was at the facility once or twice a week and she mentioned it several times to the nurses on duty and the V5 (Unit supervisor), V41 (Director of social services) and V14 (Assistant Administrator). V42 stated she left messages for V14 twice and did not get a call back.<br><br>On 9/8/2022 at 3:01 PM V9 (Scheduler) stated she scheduled R2 for her follow-up on 8/3/2022 and scheduled a wheelchair to transport her. V9 | S9999 | | |

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stated a day or two before she talked to the nurse on Duty about R2's transportation she found out that R2 needed a stretcher that R2's insurance would not pay for. V9 stated the transportation company would charge over $2000 for the transport. V9 stated she told the daughter this and that they would have to pay for transportation. V9 stated, V42 (Daughter of R2) told her they could not afford that.

On 9/20/2022 at 9:38 AM V9 stated she called the surgeons office a day or two before R2's follow-up appointment of 8/3/2022. V9 stated, she cancelled the appointment and asked if doctor could come to the facility or if the facility could take out the stitches. V9 stated and a few days later the surgeon's office called and said no to taking out stiches, and the surgeon needed to see R2. V9 stated, it was her responsibility to get appointment and arrange transportation. V9 stated, she did not do anything else after the initial call to the Surgeon's office. V9 stated she was not the only person who knew that the R2 needed to go to the doctor. "I did everything I was supposed to do. I'm not a nurse. No one followed up with me and I didn't hear anything else regarding R2 until the day she went out to the hospital". V9 stated she doesn't know of a policy or protocol describing what to do if an appointment is cancelled.

On 9/20/22 at 10:22 AM V5 (unit supervisor) stated, the first V5 heard that R2 missed appointment was when the V42 (R2's Daughter) came in and said R2 missed appointment and still had staples. V5 stated she spoke to V9 (scheduler) and V9 said the appointment was canceled because of insurance. V5 stated she told daughter they would look into it. V5 stated after that conversation with R2's daughter, a

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week or so later, we had care conference and the daughter brought it up again. I spoke to scheduler again the day R2 was sent out. V5 stated, V9 said she called Surgeon's office and the said they couldn't get R2 in to be seen quickly so send R2 to the emergency room. V5 stated she saw V18 (Primary Care Doctor) and asked if he could look at the patient's wound. V18 then took the sutures and staples out. V5 stated after her initial conversation with V9 more than a week ago, V5 did not do anything else regarding R2's transportation because V9 said she was dealing with the issue.

On 9/21/2022 at 12:33 PM V41 (Social Services Director LTC) stated, the care conference with V42 (R2's daughter) was on 8/31/2022 at 11:30 AM. During the conference V42 mentioned she had concerns about her mom not getting to appointment and transportation. V41 stated, no one mentioned this to her prior to the Care conference on 8/31/22. V41 stated, during the conference, she called V9 (Scheduler) to ask about what was going on with R2's appointment. V41 stated that V9 said there was a problem with transportation and R2 not fitting in wheelchair. V41 stated, V9 said she was working on it, and they were going to try to reschedule the appointment.

On 9/20/2022 10:03AM V2 (DON) was not aware of the situation with R2. V2 stated, it was V9's responsibility to reschedule the appointment and arrange transportation. V2 stated, she is not sure if they would have come to different conclusion but V9 could have come to her or administrator to see if we could work out payment or something. V2 stated, it did not make sense for V9 to do nothing else after the initial call to the surgeon's office.

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| S9999 | Continued From page 6<br><br>On 9/21/2022 at 2:29 PM V44 (Wound Care Nurse) stated R2's Surgical wound had no signs infection or necrotic tissue on the admission of 7/21/2022 and she would have documented it if there was. V44 stated, wound evaluations should be done weekly. V44 stated she did not complete weekly wound assessments. V44 stated, the wound care nurse or wound care coordinator are responsible for doing weekly wound assessments, but V44 was still in training. V44 stated V13 wound care coordinator was doing the weekly assessments because V44 was in training. V44 stated, "What I was told is when a resident has a surgical site they need to follow up with the surgeon. The facility's wound care doctor does not follow the surgical patient's". V44 stated, she notified the nurse on duty of the dehiscence and eschar and told her that R2 probably needs to follow up with surgeon. V44 stated, she also told V13 (Wound Care coordinator) and showed V13 the pictures because V13 was training V44 and she had to show her all of her work. V44 stated she did not notify the R2's surgeon or doctor of the change in wound. V44 stated, V13 usually handles any change of condition notifications.<br><br>Review of R2's nurse progress note dated 9/1/2022 at 1:00 PM by V4 documents the following: patient was sent out to the hospital by physician order for suspected infection to site, left leg.<br><br>R1's vascular surgeon, V16 documents in his operative report dated 9/1/2022 the following:<br>Preoperative Diagnosis: Dehiscence and infection of the left above knee amputation.<br>Procedure performed: excisional debridement of left above knee amputation wound. | S9999 | | |

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| S9999 | Continued From page 7<br><br>Findings: liquefactive fibrinous necrosis of the subcutaneous fat essentially down to the level of the adductor and hamstring myodesis. There is some purulent fluid deep to this fat and it was sent for microbiological analysis.<br>Indications: This is a 73 year old woman who presented to the emergency room for evaluation of dehiscence and concern for infection of a left above -knee amputation that was performed in July. She never followed up as an outpatient despite communication with the nursing facility regarding the importance of outpatient office postoperative follow up. The nursing facility would not facilitate transportation for the patient to be evaluated as an outpatient and requested to remove the sutures at the facility, which my office communicated was not acceptable solution for this. However, she now subsequently presents to the emergency room with no sutures in place and dehiscence of the wound with obvious liquefactive necrosis of the underlying subcutaneous fat and is indicated for operative exploration and excisional debridement of the nonviable tissues both to stabilize the wound and determine if a revisional above-knee amputation is necessary.<br><br>On 9/13/2022 at 3:35 PM V2 (DON) stated, the facility's protocol is that wounds should be assessed upon admission and weekly and documented. V2 stated, there is a skin and wound form, and a picture should be taken weekly. V2 stated, all wounds including surgical wounds should be assessed for measurements, notate any drainage, redness, edema or other signs of infection. V2 stated, if there is any change in condition or signs of infection like redness or tenderness, increase drainage, pain, or foul odor, the staff should notify the doctor immediately. | S9999 | | |

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| S9999 | Continued From page 8<br><br>The facility's Appointment and Transportation policy documents the following: 9. If the resident is unable to keep the appointment, it is the staff nurse or designee's responsibility to cancel the appointment and reschedule it at the earliest time.<br><br>The facility's Skin Management: monitoring of wounds and documentation documents the following: With each dressing change or at least weekly (and more often when indicated by wound complications or changes in wound characteristics), and evaluation if the PU/PI should be documented. At minimum, documentation should include: Location and staging; size; exudate, if present and type, Pain; wound bed: color and type of tissue/character including evidence of healing; and description of wound edges and surrounding tissue as appropriate. If a wound shows no signs of healing after 3 weeks, a reevaluation of the treatment plan including determining whether to continue or modify the current interventions is done. If the decision is made to retain the current regimen, documentation of the rationale for continuing the current plan will occur.<br>(A)<br><br>Statement of Licensure Violations (2 of 4):<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br>300.1220b)3)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the | S9999 | | |

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| S9999 | Continued From page 9<br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><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 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><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><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><br>b) The DON shall supervise and oversee the nursing services of the facility, including: | S9999 | | |

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| S9999 | Continued From page 10<br><br>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.<br><br>These requirements were not met as evidenced by:<br><br>A. Based on interview and record review the facility failed to implement fall prevention interventions to minimize fall risks for a resident with history of multiple falls, poor safety awareness, and unsteady gait. This failure affects 1 of 3 residents (R4) reviewed for falls. This failure resulted in R4 slipping and falling to the floor then sent to the hospital and diagnosed with a non-displaced left intertrochanteric fracture.<br><br>Findings include:<br><br>A. R4 was admitted to the facility on 8/26/22. R4 face sheet shows diagnosis for speech and language deficits following a cerebral infraction, hemiplegia and hemiparesis following cerebral infraction affecting the right dominant side, weakness and hypertensive heart disease, dementia in other disease without behavior disturbance. | S9999 | | |

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| S9999 | Continued From page 11<br><br>R4's facility admission hospital report dated 8/26/22 shows in-part, handwritten by V25 (Nurse) multiple falls, unsteady on feet.<br>On 9/15/22 at 3:58p.m V25 (RN) stated she received an admission report from the hospital nurse who mentioned that R4 has an unsteady gait and a history of multiple falls. V25 said the nurse did not say R4 had any fractures during the facility-to-facility report.<br><br>R4 MDS dated 8/31/22, section J for fall history denotes no fall history for R4. Section C shows a BIMS score of 9 (cognitive deficits). Section G shows R4 required extensive assistance (R4 involved in activity, staff provide weight bearing support) with bed mobility and needed one-person physical assist. R4 required extensive assistance (R4 involved in activity, staff provide weight bearing support) with transfers and needed two-person physical assist. Walk in room/ corridor- activity did not occur, locomotion on unit-shows R4 required extensive assist (R4 involved in activity, staff provide weight bearing support) with one-person physical assist. Locomotion off unit shows R4 assist extensive assistance (R4 involved in activity, staff provide weight bearing support) with two-person physical assist. Dressing shows R4 required extensive assistance (R4 involved in activity, staff provide weight bearing support) with two-person physical assist. Eating shows R4 required extensive assistance (R4 involved in activity, staff provide weight bearing support) with one-person physical assist, toilet use shows R4 required extensive assistance (R4 involved in activity, staff provide weight bearing support) with one-person physical assist, personal hygiene shows R4 required extensive assistance (R4 involved in activity, staff provide weight bearing support) with one-person | S9999 | | |

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| S9999 | Continued From page 12<br>physical assist.<br><br>R4 base line plan of care dated 8/26/22 shows in-part falls, resident (R4) is at risk for falls, resident will remain free of falls through next review, interventions show call light within reach, provide clutter free environment, encourage use of assistive devices, provide proper well-maintained footwear.<br><br>R4 occupational therapy evaluation and treatment plan dated 8/26/22 under assessment summary shows R4 presents with impairment in dysarthria, memory, sequencing/ segmentation, following instructions, safety judgement/ awareness, unsteady functional transfers, hands dexterity and self-care.<br><br>R4 fall risk evaluation dated 8/27/22 shows score of 18 (high fall risk), reason for assessment initial/ readmission, mobility- unsteady gait and or use of ambulatory devices, decreased mobility, predisposing conditions- HTN, CVA, Parkinson, hypotension, seizures, osteoporosis, physical restraint- none, visual/ hearing- no deficits, mentation- confused, impaired memory or judgement, falls, accidents, fractures- none, age- 75 and above, medications- none, elimination status- incontinent.<br><br>R4 physician telehealth evaluation for date of service 8/26/22, signed dated of 8/29/22 shows in-part fall Risk: keep call bell in reach. PT/OT evaluation related to fall risk. Fall precautions per facility policy. Patient is at risk for falls due to weakness. Patient is at risk for falls due to CVA. M6281 - Muscle weakness (generalized), Does the patient have any acute symptoms OR complaints? No History of Present Illness (TE): Patient was admitted to the facility and is awaiting | S9999 | | |

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| S9999 | Continued From page 13<br>full H&P (history and physical) and review by the primary team. The nurse consulted (company name) to review and reconcile discharge medications and orders and to ensure safe transition of care.<br><br>Facility final report to the department dated 9/8/22 reported by V2 (DON-Director of Nursing) shows in-part date event occurred 9/1/22, during nurse assessment noted with swelling and pain to left knee with decreased mobility. Order obtained to send resident to ER for evaluation, X ray result at hospital showed left hip fracture. Staff interview and no report of fall or incident during the 4 days he was in the facility. Resident has a history of multiple falls prior to admitting. Hospital report noted osteopenia throughout bones and joint of left hip. Due to resident cognitive impairment and speech deficits, it is possible fracture was sustained prior to admitting to facility. Resident remains at the hospital. Care plan to be updated upon return. Facility ruled out abuse.<br><br>On 9/15/22 at 2:10p.m V23 (CNA) said she worked with R4 on 8/30/22 on the morning shift. V23 said around 10:30am she went into R4's room to pick up breakfast trays and to check on R4. V23 said she observed R4 out of bed sitting on the floor mat next to the bed. V23 said she immediately went to get the nurse (V24) to assist her to get R4 up off the floor/ floormat. V23 said V24 and herself lifted R4 up manually (placing their arms under his arms and brought R4 to a standing position) and placed R4 in the bed. V23 said she then put an adult brief on R4. V23 said R4 was then placed in the chair (transferring R4 from the bed) and taken to the nurses station for observation. V23 said R4 was in another room when R4 fell. V23 said R4 was on the floormat and the mattress was on the opposite side of the | S9999 | | |

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| S9999 | Continued From page 14<br>bed. V23 said she didn't remember R4 having on any footwear on (shoes or grip footies). V23 said she does not know if V24 assessed R4 because after they picked R4 up she left the room to get the adult chair for R4. V23 said R4 was a fall risk.<br><br>On 9/16/22 at 10:01a.m V24 (Nurse) said she was the nurse working with R4 on 8/30/22 when R4 was observed out of the bed. V24 said the top half of R4's body was in the bed and the bottom portion of R4 body was off the mattress. V24 said she assisted V23 to get R4 up from that position. V24 said she checked R4's body for bruises, bleeding, and any swelling. V24 said she took R4's vitals and assessed R4 for pain. V24 said she did not report this occurrence immediately to V2 (Director of nursing), V28 (Restorative Nurse) or the manager on duty because she did not consider R4 to have sustained a fall. V24 said V3 (ADON) did contact her last week and asked her to give a detail statement of what occurred on 8/30/22 during her shift. V24 said she thought she gave a detailed statement when she reported that R4 was attempting to get out of bed and was not on the floor. V24 said she didn't remember what R4 had on his feet. V24 said R4 would always try to get out of bed. V24 said R4 was a fall risk. V24 said R4 had the mattress on the floor, and it was as high as the bed that R4 was in, and that's why she did not consider R4 to have had a fall.<br><br>On 9/13/22 at 3:19p.m V35 (CNA-certified nursing assistant) said on 8/31/22 she worked with R4 on the 3pm to 11pm shift. V35 said she assisted R4 with dinner and after dinner R4 had an episode of vomiting. V35 said when she was cleaning R4, R4 began to scream out in pain, saying "ouch". V35 said she reported this to V19 (Nurse) said she also reported to V19 that R4 was having pain and that R4 leg did not look right. | S9999 | | |

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| S9999 | Continued From page 15<br>V35 said she did not work the entire shift and that's the only information that she can provide regarding that situation.<br><br>On 9/14/22 at 10:09a.m V19 (Nurse) said she was the nurse responsible for R4 care on 8/31/22 and R4's daughter made her aware that R4 was having pain in the knee. V19 said upon assessing R4, R4 complained of pain in the left thigh. V19 said she called the after hour physician and orders were given for an X-ray. R4's family did not want to wait for an Xray and requested R4 be sent to the hospital for further evaluation. V19 said the physician was notified and gave orders to send R4 to the hospital for further evaluation. V19 said she was not aware of R4 having a fall the previous day. V19 said she worked with R4 the entire morning and R4 did not have any complaints of pain.<br><br>On 9/16/22 at 12:01 p.m. V3 (ADON) said the facility identifies a fall as a change in planes. When R4 was observed on the floor mat at the side of the bed, that is identified as a fall. V3 said she is not familiar with the facility having a mattress that could be placed on the floor as high as the bed (when bed in lowest position).<br><br>9/16/22 at 3:322pm V28 (Restorative Nurse) said R4 is a fall risk. Review of R4's fall risk evaluation with V28, V28 said the evaluation was R4's initial admission evaluation. R4 has an unsteady gait, decrease mobility, has predisposing condition of CVA (cerebral vascular accident-stroke), R4 has confusion and impaired memory or judgement due to dementia, and experiences incontinence. Review of R4 baseline care plan with V28, V28 said R4 is at risk for falls. R4 will remain free from falls through next review, and interventions are call light within reach, staff should encourage R4 | S9999 | | |

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| S9999 | Continued From page 16<br>to use call light for assistance, V28 said provide a clutter free environment, which is to ensure the environment does not have tripping hazards, V28 said R4 should be encouraged to use assistive devices, for mobility (wheelchair) so that R4 is not up walking, and R4 should have proper, well maintained footwear. R4 should wear well fitted shoes (that encase the entire foot, shoes that he cannot trip over) or skid free socks, skid free socks keep the feet from sliding on the floor, skid free sock should be worn in bed and out of bed.<br><br>On 9/16/22 at 12:08p.m V34 (Medical Director) was contacted due to surveyor having to complete legal documentation to obtain an interview with the routine medical provider. Survey findings were reviewed with V34. V34 said any minor trauma can cause an intertrochanter hip fracture. V34 said diagnosis of osteopenia could increase the risk of an intertrochanter fracture with a fall. V34 said R4's fall on 8/30/22 could have contributed to R4's hip fracture.<br><br>R4 hospital record with encounter date shows in-part chief complaint- leg pain, fall, 74-year-old male with history of hypertension presenting from rehab with left leg pain. History obtained by daughter at bedside due to patient's dementia baseline. Patient has been in rehab. He has been doing well up until today when daughter came to visit him. Patient has been unable to walk with left leg in pain, shortened and externally rotated. Patient fell per history obtained by him. Rehab facility did not notify daughter that patient fell. Was ambulating well prior to today. No other fevers, coughs, nausea, vomiting, chest pain, shortness of breath, diarrhea. No other injuries noted. Physical exam left leg externally rotated and shortened, tenderness with log rolling, 2 plus pulse. Xray impression- moderately displaced | S9999 | | |

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| S9999 | Continued From page 17<br>intertrochanteric fracture, findings show bones/ joints- there is a moderately displaced intertrochanteric fracture. Diffuse osteopenia throughout the visualized bones. No dislocation. Soft tissue unremarkable. Clinical impression, ED diagnosis, closed left hip fracture, acute cystitis without hematuria.<br><br>Facility falls prevention and management policy dated 5/2015 with last review date 07/2022 shows in-part the facility is committed to maximizing each resident physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for prevention strategies and facilitate a safe environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be modified as needed. The fall evaluation will be completed on admission, readmission, and quarterly, significant change and after each fall. Resident at risk for falls will have fall risk identified on the interim plan of care and the ISP with interventions implemented to minimize fall risk. Evaluate the resident for any injury and notify the physician and emergency contact. Complete a fall evaluation incident report in the PCC risk management portal. A fall evaluation is completed by the nurse. A score of 10 or greater indicates the resident is at "high risk" for falls; a score of less than 10 indicates "at risk" for fall, Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence. Complete the follow up monitoring form every shift for 72 hours. All incidents and accidents with serious physical injury will be reported to IDPH within 24 hours. A full written investigation report is required by IDPH five (5) days of the incident.<br>(B) | S9999 | | |

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| S9999 | Continued From page 18<br><br>Statement of Licensure Violations (3 of 4):<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><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 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><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: | S9999 | | |

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| S9999 | Continued From page 19<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>These requirements were not met as evidenced by:<br><br>B. Based on observations, interviews and records reviewed the facility failed to provide supervision for a resident with altered mental status, unsteadiness and abnormal gait: the facility also failed to respond to an audible alarm from an exit door for approximately 14 minutes. This failure affected 1 of 3 residents reviewed for supervision. This failure resulted in door alarm alarming for 14 minutes before facility staff responded. This failure resulted in R1 walking out the 2nd floor alarmed door and later found lying on the 1st floor in the stairwell. R1 was sent to the hospital and diagnosed with a right femoral head fracture.<br><br>B. Review of R1's faces sheet documents a 71 year old male admitted to the facility on 8/17/2022 with diagnoses that include: Altered mental status, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, Dysphagia flowing cerebral infarction, Acute embolism and thrombosis of right femoral vein, Unsteadiness on feet, abnormalities of gait and mobility, lack of coordination, Malignant neoplasm of the prostate, weakness, Visuospatial deficit and spatial neglect following cerebral infarction. R1 resided on the second floor. R1 MDS section | S9999 | | |

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| S9999 | Continued From page 20<br><br>C dated 8/24/2022 documents R1 with a score of 00/15. On 9/16/2022 at 11:37 AM V29 (Social Services Coordinator) states a score of 00 BIMS (Brief Interview for Mental Status) score indicates that the resident was not able to answer questions or answered incorrect and is severely cognitively impaired.<br><br>On 9/9/2022 at 3:40 PM V15 (CNA) stated, "I was in another resident's room and the moment I walked out of the room I heard the alarm. I was in a different hallway from R1's room. I was the only CNA on the floor and the other CNA (V36) was running late". V15 stated, "I heard the alarm and went to check rooms while alarm was going off. I noticed R1 was gone then I checked the door that was alarming. I never turned alarm off at that point." V15 stated she then went to find the nurse. V15 stated she found V3 (ADON) and V14 (Assistant Administrator) on C side unit. V15 stated, she informed V3 and V14 that R1 was not in his room and the alarm was going off. V15 stated when she arrived at alarming exit door with V3 and V14, she turned the alarm off. V15 stated, that her, V3, and V14 went through the exit door down the stairs and found R1 on the first floor, lying in front of the entrance door to the 1st floor unit. V15 stated herself, V3, and V31 (CNA), got R1 up. V15 stated she could hear the alarm from the office from where V3 and V14 were standing and talking.<br><br>On 9/13/2022 at 10:21 AM V3 (ADON) stated she was working on the unit because V17 (LPN) was running late. V3 stated she was caring for another resident, speaking with their POA when V15 (CNA) told her that R1 was not in his room and the alarm had gone off. V3 stated at no point while on the floor did she hear the alarm and she was on the floor from 3:30pm unit 5 PM. | S9999 | | |

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| S9999 | Continued From page 21<br>V3 stated when she got to the exit door with V3 and V14 the exit door alarm was not on. V3 stated the exit door alarms until someone turns it off. V3 stated her, V14, and V15 went through the exit door and found R1 lying on the floor on the 1st floor.<br>On 9/13/2022 at 2:44 PM, V3 stated she arrived on the unit that day (8/30/2022) at around 3:30PM. She was on the unit from 3:30 PM until after 5:00 PM. She did not leave the unit.<br><br>V3's progress note dated 8/30/2022 at 5:40 PM documents V3 found R1 on the on the 1st floor in the stairwell laying on the floor with his back against the door.<br><br>The facility's incident report dated 8/31/2022 documents the following description of the occurrence: Resident sustained unwitnessed fall. Upon nurse assessment no signs of injury noted. No complaint of pain. Order obtained to send patient to ER for evaluation. Patient noted to have closed fracture of right hip.<br><br>Review of R1's hospital records X-ray report dated 8/30/2022 diagnosed R1 with a Right Femoral Neck Fracture.<br><br>On 9/13/2022 at 12:42 PM V32 (LPN) stated she went to break from 4:00 PM to 4:30 PM and she made V3 (ADON) aware that she was leaving.<br><br>Review of V17's (LPN) Time Card Report documents she clocked on 8/30/2022 at 4:28 PM<br><br>Review of V36's (CNA) Time Card Report documents she clocked on 8/30/2022 at 4:24 PM<br><br>On 9/13/2022 at 11:58 AM this surveyor reviewed | S9999 | | |

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| S9999 | Continued From page 22<br><br>recorded video from R1's 8/30/2022 incident in 2B hall with permission of and the presence of V1 (Administrator). Observed video recording dated 8/30/202 from 4:05 PM until 4:25 PM of the 2B that documents the following:<br><br>At 4:05PM V15 (CNA) came out of Room, went to the cart with V3 (Assistant DON) and then V15 left area (went behind the camera view).<br><br>At 4:06 PM V3 left medication room and view of the cameras.<br>At 4:07 PM R1 walked out of room with gown on. R1's gown got caught slightly on a cart. R1 walked along right wall and then crossed over to the left to the exit door.<br>At 4:09 PM R1 disappeared through the exit door.<br>At 4:22 PM - V15 (CNA) went into room with what looked like a cup in her hand. V1 came out to the cart and then went back in the room.<br>At 4:23 PM V15 left the area (behind the camera view).<br>At 4:23:41 PM V15 is back in view, she is looking around and looks into R1's room. V15 then went to exit door. V15 then went back into R1's room and looks around, then V15 leaves the area.<br>At 4:25 PM V15 came back to the 2B hall with V15 (ADON) and V14 (Assistant Administrator).<br><br>Staff responded to the alarming exit door at 4:23 PM which is 14 minutes after R1 was observed going through the 2nd floor exit door.<br><br>Review of the facility's Staff statement by V2 (DON) dated 9/5/22 documents the following: Video footage reviewed and observed resident walking in hallway unassisted to stairwell.<br><br>On 9/15/2022 at 3:37 PM V22 (Director of staffing) states that there should always be 1 | S9999 | | |

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| S9999 | Continued From page 23<br>nurse per hall that is occupied. V22 states that they always staff 2 nurses on the first and second floors for the 7:00 AM to the 3 PM (1st) shifts and the 3pm -11:00 PM (2nd) shifts. V22 states they will add a third nurse to the 2nd for if the third hall is occupied with residents. V22 states that for the 1st and 2nd shifts on both the 1st and 2nd floors the CNA's are staffed as follows: 1-15 residents =1 CNA, 16-25 residents = 2 CNAs, 26-35 residents= 3 CNA.<br><br>Review of facility's Census for 8/30/2022 documents 13 residents on 2A hall and 7 residents residing on 2A hall on the 2nd floor.<br><br>On 9/15/2022 at 3:15 PM V2 (DON) stated, on 8/30/22 there were 2 nurses and 2 CNAs scheduled to work the 2nd shift on the second floor. V2 stated, they try to have staff communicate with the other nursing or CNA who should be watching unit. V2 stated, V32 (LPN) was on break. V3 and V15 should have been monitoring the unit. Surveyor asked, if there was there anyone else on the floor monitoring the residents while V3 and V15 were occupied? V2 stated, there was no one else on the floor. V2 stated, "Ideally, there should be someone there watching the residents and monitoring the unit when other staff is occupied." V2 stated, they could have called someone to come look after the residents while they were occupied. V2 stated, "We do not have any protocol or practice to monitor the unit when the assigned staff are in with other residents." V2 (DON) stated, "I'm not aware of any of the precautions the hospital had R1 on. We don't use bed or chair alarms."<br><br>On 9/15/2022 at 4:10 PM V3 (ADON) stated when she and V15 (CNA) were helping another resident to the restroom, she was aware that | S9999 | | |

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| S9999 | Continued From page 24<br>there was no one else on the unit to monitor the other residents. V3 stated, "If we had somebody then, yes, I would have loved someone to be there to monitor other residents. I didn't call someone else because I didn't have the staff that was available to come." V3 stated, they do not have a practice or policy she knows of to monitor residents when staff is occupied in another room or otherwise.<br><br>Review of facility's Elopement policy dated 9/2022 documents the following: Guideline: 7. All facility staff are responsible for responding to a door/elevator alarm immediately. This response will include visual check of the immediate vicinity surrounding the door/elevator that tripped the alarm, including the stairwells and outside area. (A)<br><br>Statement of Licensure Violations (4 of 4):<br><br>300.1210b)<br>300.1210d)2)<br>300.1220b)3)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><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 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. | S9999 | | |

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| S9999 | Continued From page 25<br><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><br>2) All treatments and procedures shall be administered as ordered by the physician.<br><br>Section 300.1220 Supervision of Nursing Services<br><br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br><br>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.<br><br>These requirements were not met as evidenced by:<br><br>Based on observations, interviews and record reviewed the facility failed to implement a plan to prevent unplanned weight loss. This affected 1 of 4 residents (R11) reviewed for unplanned weight loss. This failure resulted in R11 losing 34% of body weight within 6 months.<br><br>Findings include: | S9999 | | |

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| S9999 | Continued From page 26<br><br>Review of R11s's faces sheet documents a 78 year old female admitted to the facility on 12/8/2021 with diagnoses that include: R1's MDS section C dated 7/1/2022 documents R11 with a (Brief Interview for Mental Status) score of 02/15 which indicates severe cognitive impairment. R11's MDs section G dated 7/1/2022 documents R11 requires extensive one person assist for eating.<br><br>On 9/20/22 at 12:15 PM V45 (Restorative) stated R11 requires assistance to be fed. From the hallway surveyor observed R11's food appears to be untouched. Milk is unopened and plastic is covering food. R11 is curled up on right side in bed. Bed is in low position and head of bed is elevated. V45 stated food was delivered at 12:00 PM and she is not understaffed with CNAs today. V45 stated she has 4-5 CNA's on the unit today.<br><br>On 9/20/2022 between 12:15 and 1:20 PM surveyor observed R11's lunch sitting at her bedside untouched and without any staff going into her room to assist her with feeding. Multiple staff walked back and forth on the unit. V39 (CNA) assigned to R11 had not been observed on the unit during this time.<br><br>On 9/20/2022 at 1:20 PM with V4 (RN) (assigned to R11 and who agreed to translate Spanish), surveyor asks resident if she wanted any food. R11 answered yes in Spanish. V4 asked R11 if she wanted to try some of the food that had been sitting (for over an hour) at R11's bedside and R11 again responded yes in Spanish. Surveyor observed cooked apples covered with plastic, open milk, silverware still wrapped and main entrée with a top covering it. V4 proceeded to help R11 eat what looks like stuffing with gravy. | S9999 | | |

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| S9999 | Continued From page 27<br><br>On 9/20/22 at 1:26 PM V39 (CNA assigned to R11) stated she was busy with other residents and then took a break and just came back 10 minutes ago.<br><br>9/20/2022 at 1:40 PM V39 (CNA) stated R11 ate 20% of her lunch tray and drank all of her chocolate milk. V39 stated, she changed R11 this morning. V39 stated, she went in R11's room during breakfast and after breakfast. V39 stated, she should be checking on residents every 2 hours. V39 stated she saw resident at 8:30 AM and around 9:30 AM after breakfast. V39 stated, the next time she saw R11 was when surveyor was up there around 1:30 PM. Surveyor asked V39 why didn't you see R11 from 9:30 AM to 1:30 PM? V39 stated, "I was checking on my residents on the other side and feeding them, and I took a break." V39 stated, no one told her that R11 needed to fed. Surveyor asked, "How do you know if someone needs assistance to eat?" V39 stated, "there is supposed to be a sheet in the resident's room to tell you how to care for her. I didn't see that in the room." V39 stated I didn't know that R11 was a feeder until V5 (ADON) and V43 (LPN) told me just now.<br><br>Review of R11's physician orders documents the following Order: Weekly weight times 4 then monthly. Record in vital signs. Ordered 12/8/2021; start date 1/1/2022.<br><br>Review of R11's Dietary Care plan documents the following: Date initiated 3/25/2022: Resident is receiving hospice care. Resident at risk for weight loss/or further weight loss due to poor oral intake, skin alterations, dysphagia, mechanically altered diet, underweight, protein calorie malnutrition. Interventions: monitor weights - | S9999 | | |

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| S9999 | Continued From page 28<br>date initiated 3/25/2022.<br><br>R2's documented weights in the Weights Summary for the last 6 months are as follows:<br>3/3/2022 = 94.2 Lbs<br>4/12/2022 = 92.2 Lbs<br>5/4/2022 = 89.8 Lbs<br>7/11/2022 = 88.6 Lbs<br><br>On 9/20/22 at 3:34 PM with V48 (Restorative) and V45 (CNA) weighed R11 with Hoyer lift. Observed R11's weight to be 61.8 lbs. (a loss of 34% of her body weight in 6 months). V48 (Restorative) stated restorative staff have the responsibility of weighing residents and stated they do not weigh hospice residents even if there is an order to weigh them. V48 stated if the order is pre-hospice orders, they do not weigh residents.<br><br>On 9/22/2022 at 9:24 AM V2 (DON) stated, "Restorative team weighs weekly or monthly depending on orders. We do not weight hospice patients." V2 stated, their practice and policy are they don't weigh hospice residents. CNA and nurses are responsible for feeding residents at time of tray delivery.<br><br>The facility's weight management policy dated 9/2022 documents:<br>1). All residents will be weighed on admission, readmission, weekly for the first 4 weeks and then at least monthly.<br>2) Weekly weights will also be done with a significant change of condition, food intake decline that has persisted for more than one week, or with a physician order. Weekly weights will not be done for a resident who is terminally ill and requests comfort care. | S9999 | | |

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| S9999 | Continued From page 29<br>The facility's Feeding Assistance policy dated 10/2021 documents the following:<br>General: To attempt to provide adequate nutrition to a resident who is unable to feed themselves by hand feeding the resident.<br>Guideline: 1. Residents who are unable to feed themselves are encouraged, instructed, assisted and/or fed by a qualified staff member.<br>(A) | S9999 | | |