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S 000	Initial Comments Annual Licensure and Certification Survey Complaint Investigation: 2280107/IL142092	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 300.1230 e) 300.1230 f) 300.3240 a) Section 300.1210 General Requirements for Nursing and Personal Care 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. 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** **Statement of Licensure Violations**	

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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.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
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 300.1230 Direct Care Staffing
e) The facility shall schedule nursing personnel so that the nursing needs of all residents are met.
f) The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs per day.

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

This REQUIREMENT is not met as evidenced by:

Based on interviews and record review, the facility failed to provide the necessary monitoring and supervision to ensure a safe environment for

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S9999	Continued From page 2 a resident and provide a quick response to assess a resident's injury or physical condition to give medical treatment for a resident who experienced an unwitnessed fall. This applies to 1 of 3 residents (R1) reviewed for falls. R1 is a physically and cognitively impaired resident (R1) who was found on the floor in a cold room unresponsive. As a result of this failure R1 became hypothermic (below normal body temperature), which required emergency medical treatment. Findings include: 1. R1's Face Sheet documents R1's diagnoses including but not limited to: Encephalopathy, unspecified, Unspecified dementia without behavioral disturbance, Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, Unspecified atrial fibrillation, Pneumothorax, unspecified, Acute respiratory failure with hypoxia, Non-rheumatic tricuspid (valve) insufficiency, Hepatic failure, unspecified without coma, Dependence on supplemental oxygen, Venous insufficiency (chronic) (peripheral), Cognitive communication deficit, Weakness, Chronic diastolic (congestive) heart failure, Personal history of malignant neoplasm of breast (History of), Respiratory failure, unspecified with hypercapnia. R1's MDS (Minimum Data Sheet) dated 12/31/21 shows R1 requires extensive two-person assistance/two or more people with transfers and bed mobility. A care plan dated 1/4/22 documents, "R1 as at	S9999		

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risk for falling R/T Weakness, Dementia, unsteadiness on feet and "Respiratory failure. I fell out of bed December 30, 2021, no injuries." R1's fall prevention intervention approach listed: Keep bed in lowest position with brakes locked; Provide resident with safety device floor mats at bedside.

According to nursing progress note dated 1/5/22 12:52 PM, at approximately 8:15 am, it was reported to this writer during morning med pass, by CNA (Certified Nursing Assistant) staff, that R1 was on the floor by the side of bed. Upon entering room, R1 was observed on the floor on the left side of R1's bed. It was also reported that R1's window was opened. Upon assessing R1 for any possible fractures, R1 was noted to be very cold. An attempt was made to check R1's temperature with a digital thermometer. R1's temperature was registering as Low in several body areas. R1 was immediately assisted to bed and wrapped with several warm blankets. At the time BP was 48/43 and pulse was 58 bpm. 911 was called immediately and R1 was transferred to hospital.

According to information obtained from local conditions.com which reports local weather conditions, the outside temperature on 1/5/22, from 6:00am to 7:30am was reported between 19.4 degrees Fahrenheit to 23 degrees Fahrenheit.

The local hospital's emergency department provider note dated 1/5/22 9:05 AM documented, "Per Emergency Medical Services, R1 was hypothermic in route with a blood glucose of 36. Bear Hugger placed on R1 for significant hypothermia."

Emergency Department Provider Note (dated

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S9999	Continued From page 4 1/5/22 12:17 PM) documents: "R1's admitting diagnosis as altered mental status and endotracheally intubated." 2. The following are interviews conducted with direct care staff members regarding the R1's fall incident of 1/5/22): On 1/11/22 at 3:14 PM, V29 (agency Certified Nursing Assistant/CNA) stated, on 1/5/22, I started work at about 7:10 AM, and when I got to the unit there was no nurse on duty. The night shift nurse left 30 minutes early and there was no nurse covering the first floor. Upon making my rounds, I saw R1 lying on the floor, wearing only an incontinent brief, and R1's window was left open. The temperatures were freezing, and R1 was laying on the floor right next to the open window. R1 was unresponsive, and extremely cold. Normally, R1 can talk, but R1 was unresponsive. R1 was freezing cold, R1 was hypothermic, and I could not get R1 to respond to me. I closed R1's window immediately because it was freezing cold in R1's room. I started calling for help but there was nobody to help me. I started shouting and nobody was on the unit to help me. Finally, I saw V28 (MDS coordinator) and V28 came to help me. V28 assessed R1 and stated that R1 was hypothermic. V28 asked another nurse that came to the floor to call 911 while V28 attempted to take R1's temperature, but R1 was so cold that the thermometer read "low". V28 tried several body parts and the thermometer read "low" every time, that's how cold R1 was. V28 took R1's blood pressure and I think it was 45/43 or something close to that. We covered R1 immediately with as many blankets as we could find. V28 and I placed R1 into bed, and then the ambulance came. I was literally crying because someone from the night shift	S9999		

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S9999	Continued From page 5 opened R1's window and left it opened, to the point that R1 was hypothermic. There was nobody providing care or supervision to the residents on the 1st floor, until V28 came to the unit. When I arrived at work, the CN's from the night shift were already gone and so was the night shift nurse, who went home early. R1 had several falls at the facility and R1's bed was high. R1's bed was not in a low position and there was no bed mat on R1's side of the bed." On 1/12/22 at 1:05 PM, V28 (MDS coordinator/LPN) stated, "I am the MDS coordinator. The nurse that was scheduled to work on the day 1/5/22 did not come to the shift, they called off and they asked me to work the floor that day. I was working the floor filling in as a floor nurse and I arrived to work on the unit at 8:10 AM. When I arrived to the 1st floor on 1/5/22, there was no nurse on duty. When you arrived to the unit to work the floor, I was notified immediately that R1 was on the floor. The CNA came to me and told me that there is a resident, R1, on the floor. I went to R1's room immediately when I was notified that there is a resident on the floor. I saw R1 laying on the floor, wearing only a diaper, on the left side of the bed, on the side next to the window. I walked into the room and R1 was on the floor, and I touched her, and R1 was very cold, very cold to the touch. R1's room was cold. When I touched R1 and noticed that she was cold, I went to get my blood pressure cuff and the thermometer because of how cold R1 felt. I grabbed the digital thermometer, and R1 was so cold that the thermometer did not read an actual number, it just read low, so I knew that I had a hypothermic resident. R1 felt hypothermic. I attempted to check R1's body temperature on several body parts but the thermometer just read low, and I knew that I had an emergency on my	S9999		

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S9999	Continued From page 6 hands. Another nurse came in that nurse was V18(Licensed Practical Nurse), and I asked V18 to call 911." V28 said, "While V18 called 911, me and another CNA assisted the resident from the floor to the bed and we wrapped the resident in blankets. R1 was not responsive. R1's blood pressure was extremely low, and her body temperature was extremely low to the point that the thermometer was not able to actually read the temperature, so I knew that I have an emergency on my hands because I had a hypothermic resident. So V29 (agency CNA) and myself helped the resident from the floor into the bed and we wrapped her in as many blankets as I could find. The ambulance came because we called them right away. I stayed with the resident until the paramedics took the resident. The paramedics arrived very quickly. I did not see the window open, but it was reported to me by the V29 that R1's window was open. I know that R1 was extremely cold, and she was hypothermic because I was not able to get a body temperature from her. V29 found R1 on the floor and with an open window, and V29 reported that to me. R1 was very cold and unresponsive. I did everything I could to help R1 and R1 was sent to the hospital immediately." On 1/13/22 at 10:44 AM, V11 (Nursing Consultant) stated, "The outgoing shift nurses and CNAs are supposed to give the incoming staff report. Giving report assures that there is continuity of care and updates the incoming staff about any clinical issues that residents may have and updates the nurse and CNA about any follow ups. If the outgoing shift fails to give report, the oncoming shift will not know what is happening to the residents. Failing to give report to the oncoming shift impedes on the resident's care.	S9999		

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S9999	Continued From page 7 When the oncoming shift comes in, they are supposed to make rounds before they receive report. When V24 (Licensed Practical Nurse/LPN) left 30 minutes early on 1/5/22, so V24 failed to provide care and supervise the residents. Because V24 left early on 1/5/22, and failed to supervise R1, and R1 was on the floor. To my knowledge, on 1/5/22 there was no nurse covering the 1st floor, where R1 resided, from 6:30am to 8:10am, so no nurse supervision for about 2 hours." Timecard Report (dated 1/5/22) shows that V24 (LPN) punched out at 6:29am. On 1/13/22 at 7:22 PM V22 (Nurse Practitioner) stated, "R1 had a few falls at the facility. R1 rolled out of bed on several occasions. If I was the director of nursing, I would have told them to put R1 closer to the nursing station. I was told that they cannot have any side rails, but R1 needs them. R1 was not in a low bed and R1 needs a low bed. For someone like R1, I would recommend a low bed and a floor mat so that R1 will not get hurt. R1 needed more monitoring. R1's fall could have been avoided if she was supervised more frequently. Since R1 had several falls previously, additional fall preventative measures should have been in place. The window should not be open with these freezing temperatures. The staff should not have opened R1's window and left R1 with an open window with these freezing temperatures to the point that R1 was hypothermic." On 1/25/22 at 10:43 AM, V23 (CNA) stated, "I am the night shift CNA. I start work at 11 PM. I get off at 7 AM. I worked on the night of 1/4/22, I started my shift at 11 PM. I was not working on the 1st floor on 1/4/22 into the morning of 1/5/22,	S9999		

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but I heard what happened to R1, when I reported for my shift on 1/5/22 at 11 PM. I heard that the resident was on the floor naked and hypothermic. I float around the facility and work different units, so I wasn't R1's permanent CNA, but I knew R1 well. R1 cannot reposition self. R1 was able to talk and was able to express needs prior to the incident. R1 was able to express that R1 was cold. I usually do rounds, and I would check on R1 every 2 hours. R1 was able to answer me if I asked R1 if she was cold. R1 was able to answer my questions, but R1 was bed bound. The expectation is that we round on the residents every two hours."

On 1/25/22 at 1:57 PM, V24 (LPN) stated, "I am familiar with R1. I worked with R1 maybe once or twice. I was the nurse assigned to R1 on the 7 PM to 7 AM shift on 1/4/22. I left work at 6:30 AM on 1/5/22. My shift ends at 7:30, so I left an hour earlier. I notified the 3rd floor supervisor, V34 (Night supervisor) and the V25 (CNA), I was working with on the 1st floor. I always leave at 6:30 AM when I work at the facility, and I always let someone know that I am leaving. I always notify someone that I am leaving early. On 1/5/22, the CNA I was working with, V25, was keeping an eye on the unit, and if there were any issues, then V25 (CNA) would report it to the night supervisor, V34. R1 was lying in bed with a gown on. The last time I saw R1 was at 6 AM on 1/5/22, and R1's window was closed, and R1 was sleeping in the bed. I saw R1, a total of 3 times during my shift on 1/4/22 to 1/5/22, at the start of my shift, middle of my shift and at 6 AM. During my shift there was a confused resident who was getting out of bed and walking around the hallway, so I had to redirect the resident. I had to walk up and down the hall with the confused resident when I was not able to redirect the resident. During my shift I

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S9999	Continued From page 9 had to redirect that confused resident about 6 times because of major confusion. V25 (CNA) was also helping me out with that resident as well by providing redirection and close monitoring. On 1/25/22 at 12:14 PM V33 (Staffing Coordinator) stated, "Typically there is one scheduled CNA on the first floor. If there are 7 or more residents on the 1st floor and at least 5 of them are total care than we schedule two CNAs. On 1/4/22, I scheduled two CNAs for the first floor, so the census was roughly about 7 to 10 residents, that's why I scheduled two CNAs for that unit. On 1/4/22 there were two agency CNAs who called off for the 11 PM-7 AM shift. As a result of the call offs, V23 (CNA) was pulled to work on the 3rd floor. On the night shift, 11 PM to 7 AM there was only one CNA working on the first floor. So V25 (CNA) was the only CNA who was working on the first floor. There was one nurse and one CNA working on the first floor 11 PM to 7 AM on 1/4/22. Nurses work a 12-hour shift, and they are not supposed to leave early. The earliest they can punch out is 5 to 7 minutes before their shift is over. If a CNA is present on the floor than the nurse can punch out at the end of her shift and write down the report for the incoming nurse on paper. But nurses are not allowed to leave 30 minutes prior to the end of a scheduled shift without letting a supervisor know. Sometimes we won't know that someone left early until the payroll is being done and the actual punches are being looked at. Nobody can leave 30 minutes prior to the end of their shift without prior authorization. When a CNA is on the unit or another nurse than the nurse can leave 7 to 5 minutes before the end of their shift, but not 30 minutes." On 1/25/22 at 12:50 PM, V25 (agency CNA)	S9999		

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S9999	Continued From page 10 stated, "I saw R1 the last time during my rounds at 6:45 AM on 1/5/22, and during my rounds R1 was lying in bed. There were two residents in R1's room. The window was closed. I did not open the window. V24 (LPN), the nurse that was working with R1, left early, around 6:30 AM. V24 told me that V24 was leaving early. When I leave the facility, I punch out on my phone because I work for an agency. I was the only CNA for the 1st floor on the night of 1/4/22 11 PM to 7 AM shift. There were approximately 30 residents on the first floor on the night shift 11 PM to 7 AM on 1/4/22. From the 30 residents, approximately 10 residents were total care residents who were bed bound. I rounded on R1 hourly. There was another resident that needed my attention because that resident was getting up out of bed every 15 minutes. That resident was coming out of the room and was confused. I never took care of R1 prior to the date of 1/4/22. When I started my shift on 1/4/22, I never received report from a CNA or the nurse. All I was told was to go make rounds and make sure that everyone was ok, but I never received any information about the residents and the care they required. I did not know any of the residents when I started my shift. When I started my shift on 1/4/22 at 11 PM all the CNAs from the 3 to 11 PM shift were gone and no report was given to me. I did not know R1 and never received report from the nurse or the CNA on how to properly care for R1. I was stuck with one resident most of the night because that resident basically needed a 1 to 1 supervision because that resident was confused so I was occupied most of the night with that resident." Timecard Report (dated 1/5/22) shows that V25 (Certified Nursing Assistant) punched out at 6:56 AM.	S9999		

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S9999	Continued From page 11 On 1/25/22 at 3:24 PM, V22 (Nurse Practitioner) stated, "It would take a couple of hours for R1 to lay next to an open window, to become hypothermic. With the temperatures of 23 to 19.4 degrees outside and with the window being open, it would take several hours for R1 to become hypothermic. Another advancing factor that might contribute to the hypothermia, is that fact that R1 was not very mobile. R1 was bed bound, so it would be a contributing factor for hypothermia as well. By several hours, I mean it would take R1 lying next to an open window for about 2 to 3 hours to become hypothermic. I'm not sure, I think it would take about 2 to 3 hours. I am trying to look it up." There were 32 residents on the unit at the time and only one nurse and one CNA. Both the CNA and the nurse stated that there was one resident who was very confused and disoriented. That resident occupied most of V24 and V25's time during that shift. Daily Census Report (dated 1/4/22) documents there were 32 residing on the 1st floor unit. "A"	S9999		