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	IL6006829	A. BUILDING: ______ B. WING ______	04/14/2022

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S 000	Initial Comments Annual Licensure and Recertification Complaint Investigation: 2292760/IL145564	S 000		
S9999	Final Observations Statement of Licensure Violations: 1/3 300.610a) 300.661 300.663a) 300.1210b) 300.3210t) 300.3240a)b)d) 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 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code.	S9999	**Attachment A** Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 Section 300.663 Registry of Certified Nursing Assistants a) An individual will be included on the Health Care Worker Registry as a certified nursing assistant when the individual has successfully completed a training program approved in accordance with the Long-Term Care Assistants and Aides Training Programs Code, successfully completes the required competency examination, and meets background check information required in Section 300.661 of this Part, and when there are no findings of abuse, neglect, or misappropriation of property in accordance with Section 955.310 of the Health Care Worker Background Check Code. 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 care needs of the resident. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Section 300.3240 Abuse and Neglect a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b)A facility employee or agent who becomes aware of abuse or neglect of a resident shall	S9999		

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S9999	Continued From page 2 immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) d) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These regulations were not met as evidenced by: Based on observation, record review and interview the facility failed to follow their abuse policy and procedures to prevent residents from being the subject of verbal abuse, sexual abuse, and intimidation from facility staff members (V20, V31 and V33). This applies to 7 sampled residents (R1, R2, R4, R11, R49, R52, R54) and has the potential to affect all 61 residents residing in the facility. Findings include: 1. On 04/05/22 at 02:15 PM during the Survey Resident Counsel Meeting, Residents voiced concerns regarding direct care staff members. The Residents initially spoke freely during the group interview, but then 2 Residents wished to remain anonymous because they were afraid of retaliation as the subjects of the concerns being voiced were related and were known to work different shifts. R52, R54, and Anonymous resident #1 agreed, that the grievance process is not always followed. Anonymous resident #1 said," staff don't always document or consider grievances from the residents because they are	S9999		

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busy. R54 said, I witnessed V20 certified nurse aide (CNA) tell my roommate R49 to shut the f*** up. We told the administrator and the Charge nurse, and they didn't do anything about it. And we must see him every day he keeps working in our room. His mother (V33, nurse) is a Nurse that works here. Anonymous #2 said, another CNA (V31) is a relative of V20 and V33 and never gives help when I need it. One time, V31 handed me a diaper, told me they had showers to do and walked out of the room. I felt humiliated because I am not able to change or clean myself up, and I felt that is what she (V31) expected me to do".

Concerns regarding the Resident Counsel meeting were relayed to V1 administrator during end of day survey meeting on 04/05/22. Survey Team requested grievance logs, Reportable investigation files and Resident Counsel Meeting minutes to be available morning of Day 3 04/06/22. These documents had been previously requested on day 1 of Survey 04/04/22.

2. R49 is a 74-year-old male admitted to the facility 11/17/21 with diagnoses that include Legal blindness and glaucoma. R49 has a BIMS score of 14 indicating a high level of cognitive functioning. R49 is alert and oriented to person, time, and situation. On 4/7/2022 at 12:07 PM the surveyor observed R49 lying quietly in the bed. The surveyor interviewed R49 regarding allegation of verbal altercation with V20. R49 showed signs of psycho-social and mental distress. When speaking, R49 raised voice, saying that he (R49) had a verbal altercation with V20. "It was couple of weeks ago that it happened." Surveyor asked if R49 reported it to anyone, R49 stated, "I told the lady who runs this establishment V1. She said she'll (V1) talk to him (V20), and his mother V33." R49 became

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increasingly irritated with the interview indicating R49's psycho-social decline. R49 sat up visibly angry and said, now that you are asking me and bringing this up again, what am I supposed to do when you leave? I still must live here. I don't want to talk anymore." The surveyors agreed to come back to speak with R49 later in the afternoon. At 2:48 PM Surveyors went to check on R49 again. Surveyor asked, "How do you feel about your interaction with V20?", R49 stated, "I don't want to be here." Surveyor asked, "How did it make you feel?", R49 stated, "I feel upset". Surveyor clarified, "Did it make you upset?", R49 stated, "Yes, it did". R49 also indicated that he(R49) feels scared and at risk of retaliation.

3. R11 is a 79-year-old woman admitted to the facility 01/03/19 with diagnoses that include Dementia, Dysphagia, and cognitive communication deficit. R11 is alert to self and has a BIMS of 03 indicating severe cognitive dysfunction. R11 is the subject of a sexual abuse allegation by staff that was reported on 02/24/22. At the time of the investigation, R11 received a general exam by the facility's Nurse Practitioner V35 on 02/24/22. R11 was not sent to the hospital for a sexual assault exam to rule out sexual abuse occurring. On 04/07/22 at 12:20pm, R11 was observed in bed, awake. R11 was not able to be interviewed.

R4 was admitted to the facility 09/03/10 and has diagnoses that include history of Cerebral Vascular Accident, Vascular Dementia and Aphasia. R4 has a BIMS of 11 which indicates moderate cognitive dysfunction. On 04/07/22 R4 was able to demonstrate to surveyors that she(R4) is alert and oriented to person, place time and situation. R4 reported the allegation of

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sexual abuse to R11 on 02/24/22.

According to a facility's incident report on 2/24/2022, R4 told a nurse aide not to wake R11 up because she (R11) was raped by V10. R4 heard abnormal noises in the middle of the night. In a interview with V10 he reported changing 3 residents in the room.

On 4/7/2022 at 12:13 PM the surveyor interviewed R4 regarding sexual abuse allegation involving R11. Surveyor asked if R4 was residing recently in a different room. R4 said, I was down the hall. I asked for my room to be changed because I had a hard time sleeping after I (R4) saw it. My roommate (R11) kept yelling out during the night. Surveyor asked if R4 remembers when police came to talk to her, R4 said, my roommate (R11) was raped at night a couple months ago by a male CNA. R4 said, the CNA came into the room through the bathroom and pulled the curtain. I think the CNA gave R11 some candy or something. And then I heard R11 making strange noise and the bed springs were squeaking. I think the CNA was on top of R11. R4 said, I told the Filipino night nurse when it happened, I don't know her name, and they didn't do anything about it. The CNA worked until the morning. I guess the CNA still works here but I haven't seen him since then, and he hasn't come in my new room. I don't' want him in here. I told the morning CNA (V10) when they came in, and she(V10) told the Administrator (V1). Surveyor asked what was the outcome of R4's police interview, R4 said, "they said I was lying because I didn't see it happen, and I guess they didn't see anything wrong. V1 came to ask me again and said the same thing, that I was lying because I didn't see anything."

Facility presented Abuse investigation report

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dated 02/24/22. Name of person accused was noted as V20 CNA with witnesses that included V33 (Nurse) who is the mother of V20. Report indicated that V1 Administrator attempted to interview R4 at the time the incident was reported by V10 CNA, however R4 fell asleep while being questioned. An hour later, V1 attempted to interview R4 again but R4 was not awake enough to answer questions. A third attempt was made with the local Police Department and R4 said that V20 had brought a bag of candy for the Residents to share, and later heard bed squeaking noises which made R4 realize sexual assault was taking place. Summary of interview with R11's family member stated that Family Representative (V21) requested for R11 to be seen by in house practitioners unless the providers or Police thought it was necessary for R11 to be sent out to the hospital. On 02/24/22, V35 Nurse Practitioner note that they examined R11 and did not notice any signs of trauma. The investigation was not substantiated by V1 Administrator and no further action was taken.

On 04/07/22 12:55 PM V1 Administrator said, "I fired the V20 CNA yesterday. It was reported to me yesterday by R54, that V20 was verbally abusive to another Resident R49". I started the investigation after the surveyors left for the day yesterday. I did not complete it and I didn't report it to the Regional Office. I don't recall speaking to R49 about this before. I do recall speaking to R49 with V33. She is V20 CNA's mother. I remember it wasn't two days ago, it was a couple weeks back".
"For the sexual abuse allegation, V20 was suspended for 3 or 4 days I don't recall. I spoke to the Resident (R11) and the I did not substantiate the allegation because the Resident who reported the issue (R4) was not totally

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S9999	Continued From page 7 cognizant when interviewed by the Police. The Resident that was the subject of the allegation (R11) is not able to be interviewed and when we notified the family, they requested that we do not send the Resident to the hospital unless it was determined by our healthcare professional and the Police investigator. The Police didn't write a report because they said that there was no camera footage, and the complainant was not a reliable interview source. I didn't place the notice of suspension in V20's personnel file because it was a part of my abuse investigation. Since I didn't put it in his (V20) file, there would be no way of knowing or recognizing a pattern of abuse for anyone unfamiliar with him (V20) or any allegations he may have been involved in. V20 was also terminated because he(V20) has not provided me with a CNA Certification. I requested the certification via a text message and phone call. I requested a call back and if he(V20) did not. I texted him(V20) around 6:00PM after dinner. This was after I told the HR manager to terminate him(V20) over the phone around 12:30PM". At approximately 4:00pm, V1 presented a preliminary investigation report of Abuse regarding V20 and R49 dated 04/07/22. On 04/06/22 09:54 AM V27 HR Director/Scheduler said, there are 3 staff members in the nursing department who are related. V33 is a nurse and the mother of CNAs V20 and V33. V33 LPN and V20 CNA often work the same shifts together. V31 CNA usually works the evening shift, and sometimes they pick up on other shifts or stay over when we are short. I started working in this facility 02/28/22. I am(V27) not aware of any complaints or concerns about any of them.	S9999		

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Surveyor asked V27 for the personnel files of V20, V31 and V33. V20, V31 and V33 all had start dates of 01/15/22. Facility presented documentation dated 01/14/22 which indicated V20 was listed on the Illinois Health Care Worker Registry (HWCR), with no indication of CNA course completion, and no attempts at taking the CNA exam. V20 had an Illinois State and National Sex Offender check completed 02/24/22. V20 electronically signed the facility provided abuse policy on 01/13/22.

At approximately 2:00PM, V27 said, "I have a list of all the background checks that are supposed to be completed before hire. I didn't find that V20, V31 and V33 had them, so I ran them today. They all had the background checks of the HCWR, but I ran all the others and there were no hits against them. I can't say why it wasn't done at the time of hire, but I have a list of checks that need to be completed before hired staff can work. V20 doesn't have any write-ups in the file".

Surveyor reviewed files of V31. HCWR indicated CNA training was completed 2/16/17. No additional background checks were available to review before or at the time of hire. Within the file, two corrective action forms were observed signed by V1 Administrator and V2 Director of Nursing (DON). The two forms did not have any explanation of the action to be corrected. When V2 DON was asked about this, V2 said I will find out and bring them back". V2 DON later presented that V31 received a Corrective Action with "Written Warning" from the facility on 03/24/22 regarding "Customer Service Policy" with the following explanation: Employee states that with her weight she must exert more effort

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while cleaning them, which makes the resident think she is being rough with them. On 04/01/22, a Corrective Action "Final Warning" was given with the following explanation: "Employee states that she feels like the resident thinks she is yelling while wearing her mask." Both Corrective Actions were signed by V1 Administrator and V2 Director of nursing and were not signed by V31. On 04/06/22 V2 said that "no further action was taken, or investigation conducted regarding these incidents. The Residents were not named in the Corrective action, so I cannot recall who was affected at that time".

On 04/09/22 at 7:57PM V31 CNA said, "I (V31) was terminated from the facility on Friday 04/08/22. I was told there were allegations against me and repeated patterns. They didn't tell me what the repeated patterns were. I(V31)have never received any write-ups from the facility, and if I did, I didn't sign any paperwork for anything. I started working in the facility January 15, 2022. I haven't taken the certification test yet".
"I was given a verbal warning about changing the residents. The Administrator and the Director of Nursing told me that the residents were saying that I was rude or rough with them. I had 3 warnings in total. Some residents also said I was yelling at them, or they couldn't hear me. Then some residents said that I refused to change them. I don't know how these residents are used to being told they must wait, but if I'm already doing something or getting ready to give someone a shower, I tell them they have to wait until I am done. I'm still learning the residents and they are still teaching me. So, for them to say that I'm being rude or mean, I don't know what to say. With the other complaint about me, turns out I was too rough rolling a bariatric Resident. I'm 5'3 and 130lbs and a lot of times I work short, and

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the nurses don't always help. I don't have a lot of upper body strength, so I have to the best I can with rolling them so I can get them clean. I haven't been made aware of any additional complaints or concerns about me".
"The current DON fired me over the phone on Friday 04/09/22. The current administrator hired me in January, and she knew that I didn't have a CNA certification. She asked me again about it this week and know I'm scheduled to take the test 04/13/22 next Wednesday. I last worked this past Wednesday 2nd shift 3-11. I was scheduled to work Thursday, and when I came in to work, they told me to go home and didn't tell me why".
V33 LPN personnel files were reviewed. No Corrective Actions were documented.
Attempts to contact V33 LPN unsuccessful. Message left with return call request on 04/09/22.

On 04/09/2022 at 5:49PM V36 Medical Director said, I have not been informed of any issues pertaining to abuse in the building and I was not made aware of any allegation of sexual abuse. I should have been made aware of this allegation as the Medical Director. I don't know what the investigation revealed because I wasn't notified. To perform a proper exam for sexual assault, we have to take of course to get a special certification. If sexual abuse were to occur, the facility should file a report and send the resident to the ER. We don't do sexual assault exams in the nursing facility because would be biased. If the family refused for the Resident to go to the hospital, and I would explain to the family that we would have to prove otherwise that the abuse didn't happen.
At 6:05PM V10 CNA said, Oct 19, 2021, "if I witness or its reported, I will let my nurse, DON or administrator know. I don't know about any reoccurring. I have had to report abuse before on

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the morning shift, when I went to do patient care for R11, R4 said that I should leave her alone. R4 said one of the CNAs raped the lady next to her R11. I asked if R4 could physically see R11. R4 said the male CNA came through the bathroom door, and he was on top of her. I asked if she knew the name, but she didn't. I went and told the administrator. We went back to the room and R4 said the same thing. R4 is very alert; this is the first time I've ever heard anything like this before from R4. R4 has never made any claims before about residents or staff". There are cameras in the hallways leading up to the room in the hallway and in the dining room.

At 6:15PM V35 Nurse Practitioner (NP) said, I am the house NP. I started in February 2022. When I arrived at the facility 2/24/22, I was notified of an alleged sexual assault. It was the first time I'd met R11. I went in to see R11 with another staff member. R11 is nonverbal, smiles and responds to R11 name. I did an assessment and checked for redness, bleeding, scars, or bruising focusing on the genital area and oral. I don't have any experience to do an exam for sexual assault, but while in school during training, we learned to do this. I don't have a certification, it's part of the program for women's health. I didn't obtain any specimens.

At 7:08PM V20 CNA stated," I no longer work at the facility. I was terminated Friday 04/08/22. V1 Administrator called to discuss some Residents making complaints about me. One Resident R49, complained that I told him(R49) to shut up.
I was also told that there was a complaint about me and R49. The last day I worked was Tuesday. I was told not to come in on Thursday and Friday I was terminated of this week. I haven't been

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S9999	Continued From page 12 written up for anything before. I usually take care of the same set of Residents for a week and then the assignment changes. The day I got into an altercation with R49, he(R49) was up in arms I would say. He's blind but R49 is independent. So, I told him(R49) I wouldn't make his(R49) bed because R49 could make it himself and I told R49 to shut up. My mom (V33 LPN) told me that it would be a strike against me because I said that. This happened about two weeks ago. My mom (V33) who's a nurse at the facility was on shift at the time. My mom (V33) notified the ADON (assistant director of nursing) or the DON about the issue and asked how to proceed. My mom told me I wasn't supposed to say that because it's considered abuse. I consider abuse to be physical harm or neglect, but I can see now how verbal altercations can be considered abuse. I took an abuse course, and we discussed all the types of abuse while in CNA training. I didn't take the CNA exam because I started working as soon as I finished the class. I was hired by the V1 Administrator who knew that I didn't take the exam yet. I know that some of the Residents don't like me". "They never told me who the sexual abuse allegation was about. When that happened, they suspended me for a week and brought me back. No one interviewed me about the incident, and I never talked to the police. When I came back, there was nothing for me to sign. I was off on the day the administrator called me about it. I don't have any knowledge of any residents that I am not allowed to work with. I've been warned about working with R11. I don't remember who warned me, but I am assuming that R11 may be who the sexual allegation was about. R11 moans and makes noises when you change her and the bed squeaks when it moves because sometimes it's not locked. I'm assuming that's why they thought I	S9999		

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S9999	Continued From page 13 was having sex with her(R11)". I think that the allegation was against R11. I have worked with her(R11) after the allegation because I was told that nothing was found. She(R11) doesn't talk, but she(R11) listens and pays attention. Her(R11) roommate at the time R4 didn't like me. R4 said I was too young to change her. She is not in that room anymore. Right before I came to work at this facility, I worked at another nursing home. I resigned in December of 2021 because the nurses there were making false complaints about me. I was getting false write-ups for petty things, so I left. My mom (V33) and sister (V31) both were there also and left when I did. They left because they said their checks were shortened. We came to the facility to work together". Facility Policy on Abuse reviewed. The policy states in part; "Resident and family concerns will be recorded, reviewed, addressed and responded to using the facility's grievance procedures. Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property to the administrator ... Upon learning of the report, the administrator or a designee shall initiate an incident investigation. Protection of Resident: Employees of this facility who have been accused of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator. Investigation Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the	S9999		

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incident and the resident, if interview able.
Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly works, will be interviewed to determine whether any one has witnessed any prior abuse, neglect, exploitation, mistreatment, or misappropriation of resident property by the accused individual.
Quality Management Review: Any investigation that concluded that abuse, neglect, exploitation, mistreatment, or misappropriation of resident property occurred shall be reviewed by the facility Quality Management committee for possible changes in facility practices to ensure that similar events do not occur again.
All alleged violations involving abuse, ...are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse.
In addition, the facility policy lacks any instructions on what procedure should be done for alleged victim of rape.

(B)

2/3
300.610a)
300.1210b)
300.1210d)2)
300.1220b)2)

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

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S9999	Continued From page 15 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 care needs of the resident. Section 300.1210 General Requirements for Nursing and Personal Care 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: 2)All treatments and procedures shall be administered as ordered by the physician. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 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.	S9999		

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These regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to assess, treat and manage pain for 1 of 44 residents (R411) reviewed for pain. This failure has caused R411 to experience sadness and constant pain due to staff not addressing pain concerns since time of admission. Findings include:

R411 is a 67 year old male who was newly admitted to the facility 03/21/22 with diagnoses of Cellulitis of the Right Upper Limb, Displaced Fracture of Olecranon Process, and Olecranon Bursitis of the Right elbow. The facility assessed R411 on 03/30/22 to have a cognitive score of 00, however upon assessment and interview with Surveyor, R411 was alert and oriented to person, place, time and event.

04/05/22 01:02PM R411 observed sitting in dining room R411 is speaking and says that his(R411) arm hurts. V11 walks away. R411 lifts Right arm. Black sutures are noted to the elbow. R411 said, my arm really hurts. I tell them and they don't help me. That makes me sad. They don't give me any medication or anything for my pain even when I ask. They don't listen to me. I haven't had any pain medication since I've been here.

On 04/07/22 at 10:27 AM V2 DON said, R411 is a new and recent admission to the facility. He(R411) is currently receiving intravenous antibiotics and wound care to a surgical wound. A comprehensive pain assessment should have been completed at the time of admission as a standard for all residents. It is reasonable to believe that R411 would experience some pain because he(R411) had surgery in the hospital and

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has sutures to the arm. After reviewing the orders listed, R411 has not been receiving any pain medication since admission. The nurses should be assessing the Resident for pain every shift and as needed. If there was no order available at the time of admission, I expect that the nurse should have at least asked the admitting doctor for a PRN (as needed) to address pain issues that would be anticipated. They did not do that.

04/09/2022 V36 Medical Director said, the attending should examine the patient as a new admit and come up with a pain management plan. The nurses and physician should assess pain on a regular basis such as with vital signs. I would anticipate that a patient with surgery would have pain. I would order acetaminophen or ibuprofen to give upon request for complaints of pain. If the pain was not managed, we would re-evaluate from there.

R411's Care plan for right elbow pain related to past surgery dated 03/24/22 was reviewed. One single intervention was noted which states as written; "Administer analgesia (specify medication) as per orders. Give ½ hour before treatments or care."
Immediately following, a care plan was initiated with a Focus that states; "I have a surgical incision/wound. Site: R elbow". No goals or interventions were noted to address this issue.
R411's Medication Administration Record dated April 2022 notes that nurses have assessed R411's pain as 0 across all shifts. Physician Order Sheet dated from 03/21/22 to current does not list any interventions for pain. Comprehensive Pain Assessment effective 03/21/22 was presented by the facility as an incomplete document and was signed 04/07/22.

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Facility Provided Policy titled "Pain Management Program" revised 07/18 states in part; It is the goall of the facility to facilitate resident independence, promote resident comfort, preserve and enhance resident dignity and facilitate life involvement. The pain mangaent program includes the following components: Medications for the control or relief of anxiety related to pain. Standards:
Pain assessment protocol will be initiated under any of the following situations:
1a. Any indication of pain based on the pain assessment performed for each resident at the time of admission and with any condition change and/or incident associated with the potential of pain.

1g. Resident has diagnosis of a disease that is associated with pain or discomfort

6. Pharmacological and nonpharmacological interventions will be included in the care plan and addressed in direct and indirect care assignments.

7. Care plans will be reviewed and updated each time the resident's pain management plan is found not to be effective and at least at each quarterly care conference.
9.Resident and family/sponsor education includes but is not limited to:
a. Types of pain the resident actually or potentially may experience
b. Pain control mechanisms available and/or have been employed.

(B)

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S9999	Continued From page 19 300.610a) 300.1210b) 300.1210d)5) 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 care needs of the resident. Section 300.1210 General Requirements for Nursing and Personal Care 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour,	S9999		

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seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These regulations were not met as evidenced by:

Based on observation, interviews and record reviews, the facility failed to implement interventions in preventing the reopening of a healed pressure ulcer site by keeping a resident clean and dry; and failed to ensure proper functioning of a low air loss mattress for two (R4 and R30) of four residents in a sample of 44 reviewed for pressure ulcers. These deficiencies resulted in R4's healed pressure ulcer on the sacrum reopened to Stage 3; and R30's healed pressure ulcer on the right ischial reopened to Stage 3.

Findings include:

1. R30 is a 79 year - old female, initially admitted in the facility on 12/04/21 with diagnoses of Paraplegia, Complete; Uninhibited Neuropathic Bladder, Not Elsewhere Classified and Urethral Disorder, Unspecified.

According to wound care notes dated 09/22/20, R30 was assessed for buttock pressure injuries due to urinary catheter leaking and frequent displacement. Wound notes indicated Stage 3 pressure ulcer on the right buttock.

R30's wound notes recorded the following:
10/12/21: Right ischial, MASD

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S9999	Continued From page 21 (moisture-associated skin damage); skin problem sites: right ischial, perineal; Wound#4: right ischial 3 10/26/21: right ischial, MASD; skin problem sites: perineal 02/15/22: CC (chief complaint): MASD; skin problem sites - sacral/perineal 02/22/22: CC-MASD and right ischial ulcers; Wound #7: right ischial 3, exudate is light. Infection or inflammation is none. Measurement: 1cm (centimeters) x 3cm x 0.1cm Wound related diagnosis: Pressure ulcer of contig site of back, buttock and hip, Stage 3 right ischial. Incontinence without sensory awareness-patient (R30) is frequently checked and cleaned per staff. There is risk for MASD and skin breakdown. Plan Of Care: Continue with skin ulcer prevention protocol of the facility including daily skin check; bowel and bladder management for incontinence. 03/01/22: Pressure ulcer on site of back, buttock and hip, Stage 3 right ischial; Measurements: 4cm x 7cm x 0.1cm R30's weekly skin observations progress notes documented: 01/31/22 - skin concerns: skin intact, no concerns noted. 02/14/22 - observed right thigh (rear) - MASD skin concerns 02/21/22 - other (specify) - right ischial open area; sacrum-perineal MASD Physician Order Sheets (POS) dated 02/22/22 documented: medicated cream 0.75% apply to right ischium topically every day shift for open area contamination. On 04/04/22 at 12:30 PM, R30 was interviewed regarding pressure ulcer concerns. R30 stated,	S9999		

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"They are not changing me on time. My wound reopened because it's all wet. My catheter is leaking for a couple of months now. I am going to see the Urologist today." According to POS dated 12/06/21, R30 has an order for an indwelling urinary catheter due to a Neurogenic Bladder related to Spinal Cord Injury. At this time also, V3 (Wound Care Nurse) was observed starting to perform wound care on R30. When V3 turned R30 to her (R30) left side, it was observed that there was no dressing covering her (R30) right ischial pressure ulcer. V3 verbalized, "It probably came off, no one told me. They are supposed to tell me. She had it completely healed and it reopened, probably three weeks ago. We have to make sure her dressing is intact to prevent contamination of the wound from urine and feces." It was also observed that R30's incontinence brief was fully soaked with urine along with the two disposable incontinence bed pads placed on her (R30) lower back. Her (R30) pressure ulcer wound was resting on the wet brief and bed pads. V3 was asked why R30's wound reopened. V3 stated, "It is because of the wet brief. Her (R30) catheter has an issue with leaking and it causes the soaked brief and pads. She has appointments to see the Urologist for evaluation. She needs to be kept dry, changed more often, every hour and when needed. She is a heavy wetter, so she needs to be check every hour." It was also observed that her (R30) low air loss mattress is covered with a flat sheet, and with two disposable incontinence bed pads in addition to the brief she (R30) was wearing. V3 verbalized, "It should be the flat sheet and the disposable bed pad, because the thicker the sheets, more pressure is put on the wound."

Care Plan (revision date 10/28/21) recorded: (R30) has functional bladder incontinence related

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to inability to control urination and lack of sensation for the need to urinate.
Interventions: Brief use: The resident uses bariatric disposable briefs. Change every two hours and PRN (when needed); Clean peri-area with each incontinence episode; Incontinent: Check every two hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after each incontinence episodes.

On 04/05/22 at 11:50 AM, V4 (Nurse Practitioner for Wound) was interviewed regarding R30's right ischial pressure ulcer. V4 replied, "She(30) had it before, on the right ischium, Stage 3 and was healed on 10/26/21. It reopened on 02/22/22 as Stage 3 because she(R30) has incontinence issues. R30 indwelling urinary catheter leaks and been replaced several times. R30 is seeing a Urologist for evaluation. R30 skin is damaged due to leakage of urine. R30 needs to be frequently changed and check every one to two hours, keeping R30 skin dry. More moisture from the wet brief can cause more skin damage. When R30 is wet, it is the moisture that is damaging to R30 skin. R30 pressure ulcer wound needs to be covered at all times to protect from the wet brief." Another wound care was observed with V3 and V4. During wound treatment, R30's low air loss mattress was again observed covered with a flat sheet. Three disposable incontinence bed pads were placed under R30's lower back. R30 was also wearing an incontinence brief. According to V4, "It should only be one flat sheet and the brief she is wearing. Because the air mattress does not function properly if there are too many layers. These layers produce heat adding more moisture."

On 04/07/22 at 10:10 AM, V2 (Director of

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Nursing) was interviewed regarding pressure ulcers. V2 replied, "All residents must be repositioned and checked at least every two hours. Residents who are high risk for pressure ulcer needs to have a turning schedule and must be followed. Any new skin issues or breakdown observed by staff or CNA must be reported to me or to V3. Incontinence care needs to be provided at least every two hours and as needed. For her (R30), she needs to be changed every two hours and PRN, check her every two hours and change when needed. If the wound dressing is soiled, it needs to be changed immediately by the nurse. CNAs need to notify the nurse when dressing gets soiled. Because it worsens the skin breakdown."

Facility's policy titled "Pressure Ulcer Prevention" revision date 1-15-18 documented in part but not limited to the following:
Purpose: To prevent and treat pressure sores/pressure injury.
Guidelines:
1. Maintain clean/dry skin during daily hygiene measures.
4. Keep bottom sheet dry and tightly stretched and free of wrinkles.

Facility's policy titled "Incontinence Care" revision date 4-20-21 stated in part but not limited to the following:
Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity.
Guidelines: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode.
Note: CNA (Certified Nurse Aide) shall notify the nurse immediately if any dressings are soiled or

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 25	S9999		

become dislodged during the incontinence care.

2. R4 is a 67-year-old, female, admitted in the facility on 10/28/2020 with diagnoses of Cerebral Aneurysm, Hemiplegia and Hemiparesis following Nontraumatic Intracerebral Hemorrhage, Age-related Osteoporosis, and Dysphagia.

On 4/4/2022 at 10.40 AM R4 observed lying in bed in supine position on specialty mattress.

On 4/5/2022 at 12.55 PM R4 observed lying in bed in supine position on specialty mattress again. Surveyor observed R4's dressing change performed by V4 (Nurse Practitioner for Wound) and V3 (Wound Care Nurse). V3 proceeded to position R4 for a dressing change. R4 was observed to be laying in her brief soaked with urine, additionally, one layer of blue disposable pad and one flat sheet soaked with urine as well. V3 removed the dressing and V4 assessed the wound. Wound size 0.2cm (centimeters) x 0.2cm. V3 cleaned the wound with normal saline and applied medihoney, adaptic gauze, and foam dressing as per order.
Physician order set dated 4/5/2022 reads, "Sacrum to right buttock: clean with normal saline, apply medihoney and adaptic gauze, cover with foam dressing."

On 4/5/2022 at 12.15 PM Surveyor interviewed V4. Surveyor asked when V4 noticed the wound. V4 stated, "I first saw it on 12/28/21 and it was already opened." Surveyor asked about reasons for acquiring sacrum wound, V4 indicated that some of the causes to acquire sacrum wound would be too many linen layers on the mattress that create sheer fraction and skin moisture that creates optimal environment for skin to deteriorate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006829	A. BUILDING: ______ B. WING ______	04/14/2022

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On 4/5/2022 at 1.14 PM surveyor interviewed V18 (CNA). Surveyor asked when was R4's brief changed last, V18 stated, "At 8.30 AM."

On 4/6/2022 at 10.45 AM R4 observed lying in bed in supine position on specialty mattress again.

On 4/7/2022 at 9.56 AM Surveyor interviewed V3. Surveyor asked when was R4's sacral wound first identified, V3 stated, "On 12/28/21, I think I saw it on 12/27/21 first and then I notified my Nurse Practitioner. The skin looked like there was already some tissue loss, and it was staged as sacral wound stage 3. It resolved on 1/18/22. Then there was nothing there and it reopened on 3/15/2022." Surveyor asked why the wound reopened on 3/15/2022, V3 stated, "R4 is sitting in the chair for long hours." Surveyor asked if multiple layers of linens play a role in wound reopening, V3 stated, "Yeah I guess, it irritates the skin." Surveyor asked how often should R4 be changed, V3 stated, "She should be changed every 2 hours." Surveyor recalled that V18 changed R4 at 8.30 AM and it was 1.14 PM at the time of an interview, surveyor asked V3 if this is appropriate, V3 stated," It's not, V18 should have changed R4 in between 8.30am and 1.14 PM."

On 4/7/2022 at 10.13 AM surveyor interviewed V2 (Director of Nursing). Surveyor asked what are V2's staff expectations on pressure ulcer prevention, V2 stated, "I want all residents to be repositioned and checked at least every 2 hours, high risk residents should be on turning schedule, turning schedule must be followed, any new skin issues should be reported, and if CNA discovers new skin issues, they should report it to the nurse or myself." Surveyor asked about incontinence

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S9999	Continued From page 27 care, V2 stated, "It has to be provided at least every two hours and as needed." Surveyor asked what should be done if dressing is soiled, V2 stated, "It has to be changed immediately and it doesn't have to be changed by the wound nurse, any nurse can change it." Surveyor asked if V2 is aware of R4's sacral wound, V2 stated, "I just found out last week." Surveyor asked what the cause of the wound deterioration could be, V2 stated," Staff didn't check on the resident, staff need to change and check if residents are soiled every 2 hours." Note dated 1/18/2022 reads, "Sacral wound to right buttock size 0cmx0cmx0cm resolved on 1/18/2022." Note dated 3/15/2022 reads, "Sacral wound size 3cmx2cmx0.1cm reopened on 3/15/2022" R4's Quarterly MDS (Minimum Data Set) dated 3/17/2022 shows in part R4's skin condition, determination of pressure ulcer/injury risk that R4 does not have a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. R4's pressure ulcer care plan dated 2/1/2022 states in part, "R4 has potential for pressure ulcers. Intervention/tasks: Encourage resident to change position frequently." R4's incontinence care plan dated 2/1/2022 states in part: "R4 has functional bladder incontinence. Intervention/task: Brief use: The resident uses large disposable briefs. Change every 2 hours and as needed." (B)	S9999		

Illinois Department of Public Health

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