Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005961	A. BUILDING: ______ B. WING ______	C 10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD NURSING & REHAB CENTER	152 WILMA DRIVE MARYVILLE, IL 62062

(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
S 000	Initial Comments Complaint Investigation: 2248227/IL152271	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)3 300.1220b)3 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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S9999	Continued From page 1 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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. The plan shall be reviewed at least every three months.	S9999		

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S9999	Continued From page 2	S9999		

These Requirements were NOT MET as evidenced by:

Based on observation, interview and record review, the facility to failed to assess, monitor, and implement progressive interventions to prevent self-injurious/self-harm for one of one resident (R2) reviewed for accidents/supervision in the sample of 8. This failure resulted in (R2) attempting suicide on three separate occasions resulting in emergency medical care.

.Findings include:

R2's Face Sheet documents she has diagnoses of Huntington's Disease, Depression, Unspecified Dementia, Schizophrenia and Anxiety.

R2's Care Plan, dated 3/5/22, documents "I have a diagnosis of Huntington's disease which places me at risk for medical complications and feelings of irritability, sadness or apathy, social withdrawal insomnia, fatigue and loss of energy, frequent thoughts of death, dying or suicide." With an intervention to observe for signs of depression, Mental health consult as needed based on me and my significant others direction.

R2's Minimum Data Set (MDS), dated 8/10/22, documents R2 has moderate cognitive impairment and is dependent with bed mobility, transfers, and locomotion. R2's MDS documents she has feelings of being down/depressed/hopeless, has little interest in doing things, feeling tired, poor appetite, feeling bad about yourself, trouble concentrating, thoughts that you would be better off dead or hurting yourself.

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S9999	Continued From page 3 R2's Progress Notes, document "On 06/05/2022 at 6:52 PM CNA (Certified Nurse's Aide) called nurse to the room because resident was halfway coming off the bed. Upon entering resident's room, she was observed with the call light cord wrapped around resident's neck. Resident was screaming 'I hate it here I don't want to live.' We removed the cord from her neck. Vitals at the time were stable. 110/67 (blood pressure), heart rate 96, respiratory rate 20, 02 at 98% on room air, temperature 98. No injuries to neck or other areas were noted. Resident continued saying she doesn't want to live. This nurse called emergency medical services. Resident left the building on the stretcher and is on her way to the hospital. Spoke with daughter about the situation. DON (Director of Nursing) and Administrator also aware." R2's Care Plan was not revised with progressive interventions to address R2's suicide attempt on 6/5/22. R2's Progress Notes, dated 7/23/22 at 1:35 PM document "Nurse found resident on the floor by roommate's bed with the bed cord wrapped around her neck yelling 'I want to kill myself and tell her, tell her (V17, R2's daughter)." Resident sent out emergency hospital. Administrator, daughter, and MD notified." R2's Care Plan was not revised with progressive interventions to address R2's suicide attempt on 7/23/22. R2's Progress Notes document on 8/31/22 at 2:05 PM "Resident up in wheelchair trying to throw herself forward crying and stating 'I want to kill myself' multiple staff trying to redirect and calm resident. Resident continues to cry out. Physician notified and new orders to send to ER	S9999		

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S9999	Continued From page 4 (emergency room) to evaluate and treat. Resident continues on one-on-one care until medics arrive. Will continue to monitor." R2's Progress Note dated 9/13/22 at 9:50 PM "Resident screaming non-stop since writer came on shift at PM. Saying that she is going to kill herself numerous times. Kicking at staff, attempting to throw herself out of chair. Received order from doctor to send to ER to evaluate and treat. 911 called at this time. Resident fought with ambulance/police. Report called in to hospital. Daughter notified. DON notified. Resident would not allow writer to take vital signs upon departure." R2's Progress Note dated 10/12/2022 at 2:15 PM documented "Resident tried to attempt self-harm; Res was assessed by MD and a raised area is noted around neck. Resident had no complaints of pain and showed no sign of distressed. Res was put on 1:1 observation until emergency medical services can arrive to transport resident to hospital for evaluation and treatment. MD and family notified of event." R2's Progress Note dated 10/12/22 at 3:15 PM documents "Resident up in wheelchair sitting at nurse's station, resident yelling out 'I will do it again' and 'I will hurt myself'. Resident jerking body in wc (wheelchair) trying to put herself on the floor. Resident given Ativan to help with behaviors and increased anxiety, monitoring effects. CNA sitting beside resident at this time giving one on one care. Resident has stopped jerking body and sitting calmly at this time. Vital signs stable. Raised red area noted to neck, denies pain to area. No distress noted at present. Awaiting EMS (Emergency Medical Service) to arrive at this time."	S9999		

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S9999	Continued From page 5 R2's Hospital Record, dated 10/12/22, document the following: "complaints of wrapping cord around neck, voice raspy and hoarse. Ligature marks on the anterior neck. No signs of respiratory distress. Patient having thoughts of suicide. Patient had electrical cord wrapped around her neck when found by nursing home staff. Per nursing home staff patient had cord wrapped around her neck for less than 10 minutes. Spoke with Administrator, at nursing home regarding her safety plan if discharged back to the facility. Administrator stated they will be moving her room closer to the nurse's station and checking on resident more frequently. Patient can be discharged back to the facility but ensure that the nursing home removes all power cables from patient's room. Per EMS reports, patient was tied to a chair and yelling when they arrived. States she was placed in the wheelchair after the nurses removed the cords from her neck." R2's Care Plan, dated 10/12/22, documents "I attempted self-harm", with interventions to send to Emergency Room for evaluation as needed, psychiatric evaluation as needed and increase visual checks as needed. On 10/20/22 at 8:50 AM, R2 was in her room in a low bed with 3 mats on the floor beside the bed. The call light cords were strung across to other bed in room, out of reach of resident. The power cord to R2's bed plugged in at the end of the bed and could be reached by R2 when moving towards the end of the bed. The door to the room was propped open with trash can. Staff would have to be directly in front of R2's room to see R2 from the hallway due to the door not being fully opened. R2 answers yes/no questions. R2 was unable to recall recent suicide attempt or	S9999		

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hospitalization. R2 states "yes" when asked if she tried to harm herself. R2 states "yes" when asked if she tried to wrap a cord around her neck. R2 states "no" when asked if she wants to harm herself now. R2 states "no" when asked why she tried to harm herself.

On 10/20/22 at 11:20 AM, R2 was in her room in bed, trash can was propping the door open.

On 10/20/22 at 11:35 AM, V8, Certified Nurse's Aide (CNA) and V9, CNA were in R1's room providing care, not on R2's hallway to do 15-minute check. V6, Registered Nurse (RN), ambulating with a resident by the X00 hall nurses' station not on R2's hallway to complete 15-minute check. R2 was observed in bed with trash can propping door open.

On 10/21/22 at 8:10 AM, R2 was in her room in the low bed with the head of bed elevated and the power cord to adjust the bed within her reach.

R2's Behavior Tracking, dated 10/2022, documents the following: Behavior: Attempted to do self-harm, Goal: Not to attempt to do harm to self; Interventions: 1:1 as needed or with Social Services, encourage activity (refer to football the Steelers), offer food/drink - chips, sweets, sodas, meds as ordered.

On 10/20/22 at 11:05 AM, V2, Director of Nurses (DON), states V4, Registered Nurse (RN), was the nurse working R2's hall. V2 states when she was told about R2, the doctor was at the facility, so the doctor assessed R2 and the doctor said R2 was okay, had red marks around her neck, vitals were okay, R2 did not have any loss of consciousness. V2 states she called R2's Psychiatrist doctor but was unable to reach him

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S9999	Continued From page 7 so the doctor that was here gave orders to have R2 sent to the hospital for evaluation, so they got R2 up and sat her at the nurse's station until the ambulance arrived. V2 states the cord wasn't wrapped around R2's neck "too long." V2 states staff told her that they had been in her room prior to providing care and was going back down the hallway and saw R2 with the cord around her neck. V2 states V5, Certified Nurse's Assistant (CNA) Coordinator was the one that found R2 with the cord around her neck. V2 states after this incident R2 was placed in a room close to the nurse's station but had to be moved a little further down the fall because she was exposed to COVID and had to be placed on isolation. V2 states the doctor ordered Remeron, they put the cords out of her way and put her on 15-minute safety checks and is to be in the nurses/CAN's view when going up and down the hallways. V2 states she is unsure of what interventions were in place prior to this incident. On 10/20/22 at 11:05 AM, V3, Regional Director of Clinical Operations, states R2 has a history of saying she will kill herself and when she was vocalizing that, they would send her to the ER. V3 states R2's daughter couldn't take care of her at home because she would "throw tantrums when she wouldn't get what she wanted." V3 states R2 has not had any suicidal attempts prior to the one on 10/12/22 that she is aware of. V3 states she is not aware of any other residents with suicidal thoughts/ideations or history of suicidal attempts. On 10/20/22 at 11:15 AM, V5, CNA Supervisor, states V7, Housekeeping Supervisor, reported to her that R2 had rolled out of bed, she went immediately to R2's room and R2 had the call cords wrapped around her neck and she removed the cords. V5 states R2 stated "I'm	S9999		

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S9999	Continued From page 8 going to do it again". On 10/20/22 at 11:20 AM, V6, Registered Nurse/RN, states she "thinks" R2 is on 15-minute checks but the "CNAs keep track of that." V6 states R2 has not made any active attempts to commit suicide since the one on 10/12/22. V6 states R2 can move around in the bed and puts herself on the floor. V6 states she can stand with a one assist but is unable to stand on her own. On 10/20/22 at 11:25 AM, V7, Housekeeping Supervisor, states on 10/12/22, unsure of what time, she witnessed R2 on the floor, states she told a CNA (unsure of whom), and no one checked on her right away. V7 states at that time R2 did not have any cords around her neck and doesn't "think" she had any cords in her reach. V7 states R2 "repeatedly says she'll kill herself." On 10/20/22 at 11:50 AM, V4, RN, states she was out of the building on break when R2 wrapped the cord around her neck. V4 states when she got back into the building, they had gotten R2 up and had her in the wheelchair at the nurse's station with 1:1 until the ambulance arrived. V4 states now she is on 15-minute checks and isn't to have any cords within her reach. States she "thinks" R2 has done this prior to 10/12/22. On 10/20/22 at 12:10 PM, V10, Social Services Director, states R2 was not on any behavior tracking prior to the incident on 10/12/22. On 10/21/22 at 9:30 AM, V2 states R2 was on 15-minute checks for 3 days after the suicide attempt on 10/12/22. V2 stated the 15-minute checks were discontinued because R2 wasn't having any further "outbursts or talk that she wanted to do anything." V2 states R2 is now on	S9999		

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S9999	Continued From page 9 frequent checks, which means the nurse and staff check on her when they are on the hallway. V2 states there is documentation in the nurses notes on each shift that R2 was on 15-minute checks, but not an actual 15-minute check sheet was completed on R2 that documents R2's location every 15 minutes. On 10/21/22 at 10:10 AM, V15, R2's Physician, states she was here the day R2 attempted suicide. V15 states when she was notified, she went and assessed R2. V15 states R2 was awake, alert, had marks around her neck, was agitated and was breathing and speaking fine. V15 states R2 kept stating that if she had to stay here, she was going to keep doing it. V15 states there was no negotiating with R2, she (V15) calmed her (R2) down as best she could and decided it would be best to send her out to the hospital. V15 states there was no way they could watch her as close as she needed to be if she stayed at the facility. V15 states she believes that R2's suicide threats and attempts are more of a behavior when she doesn't get what she wants, but "you have to take it seriously, she had marks around her neck and was in no frame of mind to make sense of it all." V15 agrees that an acceptable safety plan for R2 when she returned from the hospital was to remove all cords from her room, have her in a room closer to the nurse's station and check on R2 frequently and she would expect the facility to follow that. V15 states R2 "probably" would attempt suicide again. The "Suicide Threats" policy, dated 12/2007, documents "Resident suicide threats shall be taken seriously and addressed appropriately." The Policy documents "7. If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans	S9999		

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S9999	Continued From page 10 accordingly, until a physician has determined that a risk of suicide does not appear to be present." (B)	S9999		