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	IL6006472	A. BUILDING: _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

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Z 000	COMMENTS Complaint Investigation 2451171/IL169713	Z 000		
Z9999	FINDINGS Statement of Licensure Violations 350.620a) 350.700a) 350.700b) 350.700c) 350.3210a) 350.3210o) 350.3240a) 350.3240b) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents, and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.700 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a	Z9999		

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Z9999	Continued From page 1 resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 350.3210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of a facility. (Section 2-101 of the Act) o) The facility shall immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. These requirements were NOT met as evidenced by:	Z9999		

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Z9999	Continued From page 2 Based on observation, record review and interview, the facility failed to prevent neglect for one of one individual in the sample of three, (R1) who sustained an injury of unknown origin to both forearms; failed to ensure all injuries of unknown origin were reported immediately to the investigator, impacting one of three individuals in the sample, (R1) potentially affecting the remaining individuals residing at the facility, (R2-R44); failed to conduct a thorough investigation for one of three individuals in the sample, (R1) who sustained an injury of unknown origin to both forearms, potentially affecting the remaining individuals residing at the facility, (R2-R44); failed to protect 43 individuals residing at the facility, (R2-R44) when one of three individuals in the sample, (R1) sustained an injury of unknown origin to both forearms. Findings include: The facility's policy regarding abuse/and or neglect of individuals revised 1-30-08 includes, "It is the policy of this facility to provide a safe environment for the individuals served that is free from abuse, neglect, and exploitation. Mistreatment of individuals will be defined as: 4. Any willful failure to respond to a consumer's obvious needs or to provide the supervision and care needed." The policy defines neglect as, "The failure to provide adequate personal care or maintenance which failure results in a physical or mental injury or in the deterioration of an individuals' physical or mental condition." The physical injury policy dated 11-8-07 includes the administrator and investigator will be notified as soon as an injury of unknown origin is discovered.	Z9999		

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Z9999	Continued From page 3 The resident roster of 1-5-24, identifies the following: R1, R2, R10, R11, R13, R14, R27, R35, R36, R37, R42, R43, R44 function in the Mild Range of Intellectual Disabilities. R8, R12, R15, R16, R18, R24, R25, R29, R33, R34, R38, R41 function in the Moderate Range of Intellectual Disabilities. R4, R7, R19, R20, R21, R26, R28, R39 function in the Severe Range of Intellectual Disabilities. R3, R5, R6, R9, R17, R22, R23, R30, R31, R32, R40 function in the Profound Range of Intellectual Disabilities. The Individual Habilitation Plan (IHP) of 1-23-24, documents R1 functions in the Moderate Range of Intellectual Disabilities. The IHP indicates the following: R1 cannot bathe independently and needs assistance with combing her hair and feeding. R1 is able to ask and answer questions and ambulates with stand by assistance of one staff due to poor vision. The IHP documents R1 engages in self-injurious behavior (SIB) including scratching herself until she bleeds, tears her skin and picks at her scabs as well as biting herself. Incident report dated 2-7-24, documents R1 was sent to a local hospital for evaluation and treatment for possible aspiration pneumonia and was admitted the same day with the diagnosis of pneumonia and sepsis. R1's hospital nursing note dated 2-7-24 at 10:00 AM includes, "I went to put an intravenous (IV) in her forearm and noticed what looked like a ligature mark. I asked the facility staff member about it and she replied that the patient had been picking a scab and one of the co-workers got frustrated and bandaged it tightly with a self-adhesive wrap and it was left on for a couple	Z9999		

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Z9999	Continued From page 4 of days. Also stated the employee was reprimanded, possible termination. when the next facility staff came into relief (e.g. relieve) the one already there, I mentioned it to him and showed him, he said he had been off and was unaware, he was visibly upset, he is often the one taking care of the patient and seems to care for her a lot. Gave report to the floor when transferred and they were going to take pictures and document." R1's hospital nursing note dated 2-7-24 at 2:15 PM documents, "Patient arrived to floor at this time via stretcher, report received from Z4/RN (Registered Nurse). Z7/House supervisor at patient bedside and see's patient wound on left wrist and right forearm." R1's hospital nursing note dated 2-7-24 at 2:30 PM documents the following: wound number one includes a left wrist scab all the way around the wrist and is without drainage. A picture has been obtained and placed in chart. The area is scabbed, and redness noted. The wound bed and peri wound is red. Wound number two is an abrasion/scrap to the right forearm. Observation at the local hospital on 2-13-24 at 4:40 PM: R1's left wrist has a scabbed injury approximately 3 inches down from R1's hand below the wrist on the forearm. The scab is approximately 6 millimeters in width that extends all the way around the forearm. The surrounding skin is reddened, and the scab is slightly indented. The right forearm includes an approximate quarter size circular abrasion that is approximately 3 inches below the wrist. On 2-13-24 at 4:45 PM, Z4/Registered Nurse (RN) states a female staff member brought R1 to the emergency room (ER). Z4 states asking the	Z9999		

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Z9999	Continued From page 5	Z9999		

staff about the ligature mark that was on R1's arm. Z4 states the facility staff informed Z4 the facility was already aware of it and that it was caused by another staff who got frustrated and bandaged her arm tightly with self-adhesive wrap and that it was left on her arm for a couple of days. Z4 states the facility staff confirmed the staff who did this was reprimanded and possibly fired.

On 2-14-24 at 9:09 AM, Z1 states being notified on 2-7-24 by E1 that R1 was being sent to the hospital for respiratory issues and that R1 had a mark on her arm where E1 stated, "'She picked the sh*t out of it.'" Z1 states E1 described the area as being circular. Z1 states going to see R1 in the hospital on 2-7-24 and confirms seeing the circular mark on R1's right forearm, but was not aware of the large scab located on R1's left forearm. Z1 states being in shock to see the large scab on R1's left arm. Z1 states E1 did not inform Z1 about R1's left forearm.

On 2-14-24 at 3:02 PM, E5/DSP confirms accompanying R1 to the hospital on 2-7-24 and states being questioned by the emergency room (ER) nurse how R1 sustained the injury to her left forearm. E5 states informing the nurse she did not know how R1 acquired the injury and states she is not aware of R1 having any other injuries. E5 confirms to this date, E5 does not know how R1 sustained the injury to her left forearm. E5 then states, "I let E1/Administrator know on 2-7-24 that there was a laceration to her left arm when I got back from the hospital. And then that was when I went back to doing my work after I reported it. I did not have to complete any paperwork for it."

On 2-14-24 at 3:15 PM and 3:17 PM, E1 states

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Z9999	Continued From page 6	Z9999		

being notified by E5 regarding R1's injury to the left forearm on 2-7-24 and confirms going to the hospital on 2-8-24 to look at it and states, "I seen the large mark on her left arm the next morning on 2-8-24 when I went an seen R1. It was concerning." E1 states prior to being notified, E1 had no knowledge of the injury to R1's left forearm or any other marks on R1 and confirms there is no documentation on the wounds. E1 states, "I didn't report the injury or let E3/Qualified Intellectual Disabilities Professional (QIDP) know or anyone else know because I didn't know what to do. There were bigger issues going on than to worry about a mark on her arm. How do we know the hospital didn't cause her injuries? I did not know about marks to the other arm. So, no. There was no documentation completed for her injuries." E1 confirms E3 is in charge of investigations at the facility.

On 2-14-24 at 3:20 PM, E3 states not being informed of R1 having any injuries until today and confirms being in charge of investigations for injuries of unknown origin. E3 states E1 should have reported the injury to E3 once she was notified by E5 on 2-7-24. E3 states when a staff discovers an injury on a resident, the staff should be notifying a supervisor like E1, E2/Executive Director and E3. E3 states had E3 known of R1's injuries, E3 would've completed an investigation and states by the injuries not being reported and investigated, there is a potential for other residents being placed at risk for abuse, neglect and mistreatment. E3 states the facility's abuse/neglect policy and physical injury policy were not followed.

On 2-15-24 at 11:00 AM, E1 states, although an incident report was not completed for R1's injuries, a report should have been made. E1

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Z9999	Continued From page 7 confirms having the opportunity to assess R1 while she has been in the hospital and states, "I was concerned about her health and why she was there, not injuries to her arms." Facility incident reports from 12-2023 through 2-7-24 do not include incidents regarding R1's wounds to both wrists. Facility nursing notes from 11-30-2023 through 2-13-24 includes the following addressing R1's skin condition: -11/30/23 to 12/3/23: R1 has multiples superficial scratches to the left hand and wrist and right hand caused by a peer. No further documentation of injuries after 12-3-23. -12/17/23 at 7:00 AM-8:30 AM: R1 fell forward when reaching for a handrail causing a 1 centimeter (cm) laceration to the right elbow. Laceration to the right elbow cleansed with no further injuries at the present time. No further documentation of wound after 12-17-23. -1/14/23 (e.g. 1/14/24): R1 began scratching her right hand and arm causing 2x2 cm scratches side by side on top of the right arm. -1/15/24: R1 is scratching self on the right forearm. Protective sleeve applied. No further documentation of injuries to R1's right arm after 1-15-24. R1's physician order (PO) of 2-2024 includes R1's skin is to be checked weekly on Tuesday. R1's treatment record dated 2-2024 does not include documentation regarding R1's wounds to both wrists. The last entry completed on 2-6-24 for weekly skin checks with E16/LPN initials, includes documentation of a left heel sore and documents, "No other areas of concern noted."	Z9999		

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Z9999	Continued From page 8 On 2-14-24 at 9:09 AM, Z1 states being notified on 2-7-24 by E1 that R1 was being sent to the hospital for respiratory issues and that R1 had a mark on her arm where E1 stated, "'She picked the sh*t out of it.'" Z1 states E1 described the area as being circular. Z1 states going to see R1 in the hospital on 2-7-24 and confirms seeing the circular mark on R1's right forearm, but was not aware of the large scab located on R1's left forearm. Z1 states being in shock to see the large scab on R1's left arm. Z1 states E1 did not inform Z1 about R1's left forearm. On 2-15-24 at 3:14 PM, Z1 states speaking with E1 on 2-14-24 who notified Z1 that the facility was investigating the injury to R1's left forearm and believed it was caused by a wrist band being left on from R1's last hospital admission in January of 2024. Z1 states, "I feel that is a very long time for staff not to notice a wrist band that was left on causing an injury like what I seen on 2-7-24. R1 needs assistance with bathing and everything, how did no one see that area to her arm? I knew it had to be caused by something being around her wrist the way it looked, but my goodness a hospital wrist band?" Facility resident transfer sheet of 1-1-24 documents R1 was admitted to a local hospital with diagnoses of Pertussis, Dysphagia and Aspiration Pneumonia. Nursing note dated 1-10-24 includes a skin assessment upon readmission back to the facility for R1 completed by E1 which documents, "Skin warm and dry." Readmission orders include R1 should have passive range of motion to extremities (PROM) every shift. No further documentation of R1 having skin issues regarding injuries until nurse note of 1-14-24.	Z9999		

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Z9999	Continued From page 9 Nursing note dated 2-5-24 includes a skin assessment for R1 completed by E1 and includes, "Skin warm and dry. No peripheral edema." Nursing notes from 2-6-24 through 2-13-24, do not include R1 sustained any injuries of unknown origin to both forearms. (B)	Z9999		