STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145866	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Vlg Nrsg & Rhb	9246 South Roberts Road Hickory Hills, IL 60457

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34072 Based on interviews and record reviews, the facility failed to effectively supervise a resident with history of alcohol abuse. This deficient practice affected one resident (R1) out of three reviewed for supervision of an avoidable incident. R1 was able to go out into the community independently, while on a restricted community pass, somehow obtain two 1.0-liter bottles of mouthwash with alcohol, and being hospitalized later with an alcohol level of 183 (normal range is 0-10) and subsequently expiring the follow day. The Death Certificate documents the cause of death cardiopulmonary arrest due to acute kidney failure and alcohol abuse. The Immediate Jeopardy began on 1/12/25 when R1 was found yelling and screaming and with altered mental status. V1 (Administrator) and V2 DON (Director of Nursing) were notified of the immediate jeopardy on 02/04/2025 at 10:45AM. The surveyor confirmed by onsite observations, interviews, and record reviews that the immediacy was removed on 2/4/2025 but remains at level two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: On 2/1/25, V2 DON stated that V2 worked the floor 3-11PM shift on 1/12/25. V2 stated that V2 came in prior to the start of shift and made rounds on all the residents. V2 stated that V2 rounded on R1 first because V2 was informed R1 was exhibiting behaviors of screaming and lying in bed with his pushcart on top of him. V2 stated that when V2 rounded, R1 was lying in bed without his cart. V2 stated that R1 exchanged words with his roommates that day, but no physical altercation occurred. V2 stated that R1 was transported to the hospital just prior to shift change. V2 stated that R1 had an independent community access pass. V2 stated that the nurse is expected to check the residents' belongings when the resident returns from outside pass. On 2/3/25 at 10:45AM, V2 stated that residents are able to have mouthwash in their rooms. V2 stated that R1 was not observed by staff drinking the mouthwash. On 2/3/25 at 11:35AM, V2 stated that V2 spoke with the nurse and there was 1/3 of the liquid in the alcohol-based original mouthwash bottle, the cap was broke, so it was tossed out. V2 stated that it was a bigger bottle of mouthwash, one liter size. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	V5 CNA (Certified Nurse Aide) stated that V5 was assigned to R1 that day. V5 stated that R1's roommate informed V5 that R1 keeps hollering. V5 stated that V5 rounded on R1 and asked R1 if he was okay, R1 responded he was okay. V5 stated that later R1's roommates again were complaining about R1's yelling. V5 stated that V5 rounded on R1 again. V5 stated that this time V5 found an empty bottle of mouthwash on the floor. V5 stated that V5 immediately informed the nurse. V5 stated that V5 is unsure how much mouthwash R1 drank if any. V5 stated that the nurse informed her to get R1 ready because R1 was getting sent out to hospital for psychiatric evaluation. V5 stated that another staff member assisted her in getting R1 dressed and then R1 left facility. On 2/3/25 at 11:00AM, V5 CNA stated that when V5 did morning rounds, R1's roommates were complaining that R1 was hollering all night. V5 stated that later the housekeeper went into R1's room to empty garbage, then told V5 he was soiled. V5 stated that she went into R1's room and found the empty bottle of mouthwash. V5 stated that it was a large bottle with a brown label on it. V5 stated that V5 brought the empty bottle to the nurses' station and gave it to V3. V5 stated that another staff member assisted V5 with providing incontinence care to R1. V5 stated that R1 typically does his care himself and is not incontinent. V5 stated that when R1 is not lucid he is very combative. V4 RN (Registered Nurse) stated that V4 worked 3-11PM shift on 1/12. V4 stated that R1 was gone before she arrived at work. V4 stated that one of his diagnoses is screaming out. V4 stated that when R1 exhibited this behavior before and R1 informed V4 that he was having a nightmare. V4 stated that R1's screaming/moaning was increased on 1/12 and that is reason they sent him out. V3 LPN (Licensed Practical Nurse) stated that V3 was working day shift on 1/12/25. V3 stated that R1 was yelling out, talking about stuff that did not make sense, and arguing with his roommates. V3 stated that R1 had a pushcart he used when walking. V3 stated that R1 put the cart in bed on top of him. V3 stated that V3 was able to remove cart from R1's bed and place it away from R1 so R1 would not put it back in bed. V3 stated that V3 exited R1's room and notified the psychiatric physician who gave an order to send R1 to the hospital for evaluation. V3 stated that V3 notified V2 and called the hospital to give verbal report. V3 stated that R1 was transported by an outside ambulance service. V3 stated that R1 had an independent community access pass. V3 stated that the residents' bags are searched upon returning from independent pass. V3 stated that residents go to the nurses' station to have their bags checked. On 2/3/25 at 10:00AM, V3 stated that she was in and out of R1's room because he was yelling all day. V3 denied seeing a bottle of mouthwash on 1/12. V3 stated that she is unsure time she last saw R1, but R1 was alert and oriented x 4 at that time. On 2/3/25 at 10:30AM, V6 (Social Services) stated that R1 did not have an independent pass to go out into the community. V6 stated that R1 was hospitalized a couple of times due to behaviors. V6 acknowledged that R1's care plan is correct and R1 was not able to go out on independent pass, R1 could go out on supervised pass with family, friends, or staff. V6 stated that with supervised pass, the person picking up the resident has to come into facility and sign resident out and then back in again upon returning. V6 was informed that this surveyor was given independent pass sign out sheets for R1 for December and January. V6 responded that R1 was able to go out on independent pass. V6 was unable to articulate how a resident would have a restricted community pass and an independent community pass at the same time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/3/25 at 12:00PM, V8 (Nurse Practitioner) stated that anyone with alcohol abuse should not have access to alcohol or alcohol-based products. V8 stated that he is not sure how much mouthwash R1 drank on 1/12. R1's ambulance run sheet, dated 1/12/25, notes at 3:29PM a request for transport to the hospital for R1 due to behaviors was made by facility staff. The outside ambulance crew arrived at R1's bedside at 4:09PM. R1's nurse reported that R1 drank a full bottle of mouthwash and started to drink a second one before staff found R1. R1 is also reported to be alert and oriented x 4. The crew's assessment noted R1 to be alert and oriented x 1, skin cold, diaphoretic, mental status - slowed processing/response, confused, lungs with increased respiratory effort and breaths shallow. R1's hospital medical record, dated 1/12/25, notes when R1 presented to the emergency room , R1's respirations were very slow and sluggish and R1 was unresponsive. R1's pupils were poorly responsive. Oxygen saturation level 75% on room air. Narcan 2mg (milligrams) was administered sublingual and R1's breathing improving but still unresponsive. Narcan 2mg administered intravenously and R1 was intubated and placed on mechanical ventilator. Blood pressure gradually started to build up to 109/60 from 62/40. Arterial blood gas results showed severe metabolic acidosis. Poison control was contacted. R1's alcohol level was 183 (normal range is 0-10). The physician's narrative notes R1 is evaluated for drug overdose and respiratory difficulty including but not limited to mouthwash overdose. An urgent nephrology consultation was ordered for persistent severe metabolic acidosis and acute kidney failure. R1's laboratory results showed potassium level 6.1 (normal range is 3.5-5.1), creatinine (kidney function) level 4.21 (normal range is 0.6-1. 2), and blood sugar level 41 (normal range 70-99). R1's death certificate, dated 1/13/25, notes cause of death cardiopulmonary arrest due to acute kidney failure and alcohol abuse. R1's community pass sign out sheets were provided by V1 (Administrator).They are dated 12/9/24 - 12/15, 12/27 - 12/30, and 1/2/25 - 1/13. These sheets document that R1 went out on independent passes 12/9, 12/10, 12/13, 12/30, and 1/3. R1's POS (physician order sheet), dated 1/12/25 at 12:41PM, notes an order to transfer R1 to the hospital for a psychiatric evaluation. R1's involuntary petition for hospitalization , dated 1/12/25 at 1:04PM, notes R1 was seen drinking mouthwash, staring off, and staring at wall. R1's substance use/abuse care plan, dated 9/4/24, notes R1 has a history of alcohol and illegal drug abuse. R1's community access observation, dated 11/27/24, notes R1 with history of public intoxication. R1 may not access the community independently related to safety factor. R1's community access care plan, dated 9/4/24, notes R1 may not access the community independently due to physical function and therapy goals. R1 may access the community with supervision. R1's mouthwash was identified as an original mouthwash with 26.9% alcohol by volume (the equivalent of 54 proof alcohol). It also contains eucalyptol, menthol, methyl salicylate, and thymol. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The National library of medicine, dated 11/2/2023, notes poisonous ingredients in mouthwash that can be harmful in large amounts are: alcohol and methyl salicylate. Symptoms of mouthwash overdose include, but not limited to drowsiness, low body temperature, low blood pressure, low blood sugar, rapid heart rate, and rapid shallow breathing, slowed breathing, unconsciousness, and unresponsive reflexes. Per the National Library of Medicine, nonalcoholic ingredients of this mouthwash are phenolic compounds (eucalyptol, menthol, and thymol), and large-volume mouthwash ingestion will produce exposure in the toxic range of these ingredients. The phenolic compounds in mouthwash may contribute to severe metabolic acidosis, multiorgan system failure, and death. These compounds in addition to alcohol may account for the adverse effects associated with massive mouthwash ingestion. This facility's community pass policy, undated, notes approving or denying resident's independent community access or supervised community access related to, but not limited to identified risk factors in-which would place a resident in jeopardy of abuse, neglect, dehydration and any physical or psychological harm. If a resident exits the facility independently without a pass it will be assessed or evaluated to be determined whether it's an elopement, unauthorized departure, or against medical advice due to the presented risk factors. Level 1 pass privilege: resident can only access the community if he/she is accompanied by staff, family member, friend, and/or responsible party. Responsible party to inform staff the duration of pass. This facility's prohibited items policy, undated, notes residents are prohibited from possessing or having in their room any item that may pose a threat to the safety of residents. The list includes, but not limited to alcohol and potentially poisonous chemicals. The Immediate Jeopardy that began on 1/12/25 was removed on 2/4/25 when the facility took the following actions to remove the immediacy. 1. Ambulance was contacted for R1 nonemergent transfer to the hospital for behaviors. R1 was evaluated at the emergency room . 2. Facility identified residents who are at risk for obtaining contraband. This was determined by diagnosis of history of substance abuse. Independent passes were reviewed. Current substance abuse was assessed. For residents who are at risk for obtaining contraband, facility interventions include: a. Residents were interviewed and asked if they were in possession of any contraband. All residents interviewed denied having any contraband. b. Residents consented for room search with resident present and no contraband was identified. c. Residents have been offered counseling with facility counselor. d. Facility will conduct random checks with resident present to ensure no contraband is in room. Random checks will be completed once per week. e. Staff will check residents' bags upon return from out on pass to ensure no contraband is in bags. Any items identified as contraband will be removed from bags and placed in social service office. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	f. Alcohol based mouthwash will be considered contraband for residents with a substance abuse diagnosis. 3. Starting 2/4/2025 at 1pm, DON and Administrator will educate staff including staff on leave and on vacation on facility's prohibited (contraband) items. a. Staff will complete test to gauge understanding of teachings. 4. Starting 2/4/2025 at 1pm, All facility staff including staff on leave and on vacation will be educated and trained on signs and symptoms of alcohol intoxication and alcohol poisoning. a. Staff will complete test to gauge understanding of teachings. 5. Starting 2/4/2025 at 1pm, DON will in-service all nurses including nurses on leave and on vacation on Change of Condition Policy. a. Staff will complete test to gauge understanding of teachings. 6. Residents who have an independent pass and DX of substance abuse will be re-assessed for Community Pass. Started on 2/4/25 at 12pm and Completed by Social Service Director on 2/4/2025. 7. Residents who go out on pass supervised or independent will be subject to a of search bags that were brought in. a. Prohibited items will be removed immediately and kept at social service office. b. Staff will inventory bags brought in from community. c. Designee will review items that were brought in the next day for compliance. 8. Starting 2/4/2025 at 1pm, Social service will provide list of residents who are on Community Pass Restriction to Nurses to communicate any updates to ensure residents who are on restriction do not leave for independent pass. a. Nurses will be in-serviced on process. Starting 2/4/2025 at 1pm. b. It is not a new procedure to notify nurses of resident's pass privilege. Community Pass Policy Updated to reflect notification to nurses of resident's pass privilege. c. Community Pass Privilege or Restriction of Community Pass will be documented in the resident's physician orders. Community Pass Policy updated to reflect documentation in physician orders of pass status. 9. Facility held resident counsel to discuss facility's prohibited and contraband items. All residents attended. Completed 2/4/2025. a. Residents will complete test to gauge resident's understanding of teachings. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. Facility will place the list of prohibited items at the back entrance to inform family and visitors. 11. Medical Director made aware of IJ on 2/4/2025 at 12pm. 12. Administrator coordinator or designee will conduct QA studies: a. A QA study will be performed at random weekly to ensure residents who are at risk of obtaining contraband do not have prohibited items in room. The QA will be completed weekly for 3 months. b. A QA study will be performed random twice weekly to ensure staff knowledge of signs and symptoms of alcohol intoxication and alcohol poisoning. The QA will include 5 staff members twice weekly for 3 months. c. A QA study will be performed random twice weekly to ensure residents do not bring in prohibited items from the community. The QA will include 5 residents twice weekly for 3 months. d. A QA study will be performed random twice weekly to ensure that a physician order reflecting residents community pass privilege is up to date, reviewing community pass logs to ensure residents sign in and out from pass, and to ensure nurses are aware on who is restricted from community pass. e. QA audits will be presented and reviewed at the facility monthly QA meetings for three months to ensure maintained compliance, and on an as needed basis thereafter as deemed necessary by the QA committee. 13. An emergency QAPI was conducted on 2-4-2025 at 11am. 14. Date of Completion: 2/4/2025