STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008973	A. BUILDING: _____ B. WING _____	11/02/2018

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violation 300.1210a) 300.1210b)2)5) 300.1210c) 300.1210d)3)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: 2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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	S9999		

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S9999	Continued From page 2 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations were not met as evidence by: Based on observation, interview and record review the facility failed to ensure the safety of a resident with increased confusion and dementia by leaving resident unattended in the bathroom. This failure resulted in a fall that resulted in a fractured pelvis and a fractured right 10th rib for one resident and skin tear to left hand for another resident. This applies to 2 of 20 residents (R79, R28) reviewed for safety and supervision in the sample of 20. The findings include: On October 30, 2018, at 2:36 PM, V18 (R79's Daughter) was in R79's room sitting with her. R79 was in a wheelchair and was trying to converse with V18; however, R79 appeared to be confused and having difficulty focusing on the conversation and comprehending what V18 was saying. V18	S9999		

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S9999	Continued From page 3	S9999		

said she has been concerned about R79's safety because she has been having a lot of falls. V18 said R79 had just fallen within the last few weeks and hit her head and then she fell again yesterday when she was left alone in the bathroom and tried to get up on her own. V18 said she was told that a CNA (Certified Nursing Assistant) had put R79 on the toilet and had told her to "ring the bell" (pull the call light) when she was done. V18 stated she had requested that staff do not leave R79 alone in the bathroom because she has dementia. V18 said, "[R79] will most certainly get up without assistance." V18 said she was told they would pass on her request to not leave R79 alone in the bathroom. V18 said the majority of R79's falls have happened in her room or in the bathroom and have been unwitnessed. V18 said R79 will just get up and start walking across the room. V18 said she has not been notified of any changes to R79's cares in response to the falls other than reminding her to use the call light which she is unable to do.

R79's electronic nursing and progress notes showed on October 29, 2018, "CNA took resident to the bathroom and told her to put the call light on when she is done. CNA demonstrated the call light in the bathroom for her. Nurse heard resident yelling for help at 2:55 PM less than 5 minutes later and found resident on the floor. Resident was sitting on buttocks with back against the wall and feet outstretched, left arm grabbing the bar and right arm supporting herself on the floor. Resident complains of pain in her right hip. Neuro check and ROM (range of motion) WNL (within normal limits) except for right leg which she was unable to move without pain ...."

R79's electronic nursing and progress notes also

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S9999	Continued From page 4 showed several notes entered regarding R79's mental status as follows: On October 1, 2018, at 1:32 PM, V11 CRA (Certified Rehabilitation Aid) documented R79 "was unsteady with the walker, losing her balance often, leaning back, she sits with poor posture in her wheelchair often and is re-educated and corrected ..." On October 3, 2018, at 4:29 PM, V14 LPN (Licensed Practical Nurse) documented R79's "short term memory appears to be impaired .... She does display more signs of confusion ..." On October 5, 2018, at 1:18 PM, V19 Activity Assistant documented R79 "has become noticeable more confused ..." On October 9, 2018, at 10:41 PM, V14 LPN, documented "[R79] transferred herself to wheelchair tonight. When staff asked her why she transferred herself she replied because my roommate does it. Resident reminded again to not transfer herself and educated her on call light usage." On October 12, 2018, at 9:32 PM, V22 LPN documented, "At 2PM resident observed on her bedroom floor, Wheelchair was to her right and door to her left ..." On October 14, 2018, at 3:03 AM, V20 documented, " ...resident does not use call light ..." On October 17, 2018, at 9:15 PM, V14 documented, "Resident was anxious and confused tonight ..."	S9999		

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S9999	Continued From page 5 On October 18, 2018, at 10:02 PM, V14 documented, "Resident was anxious and confused tonight .... Daughter here and updated on resident's confusion." On October 21, 2018, at 5: 56 AM, V21 documented, " ...Alert with a lot of confusion. She knows her first name but not her middle name ..." On October 22, 2018, at 7:11 PM, V15 LPN, documented " ...patient is pleasantly confused." On October 27, 2018, at 3:14 PM, V15 documented, " ...intermittent confusion ..." On October 31, 2018, at 3:58 PM, V15 LPN (Licensed Practical Nurse) said R79 had been sent to the emergency room on October 29, 2018 at 2:55 PM after a fall. V15 said R79 had returned to the facility at 9:55 PM that same night and was sent back to the hospital on October 30, 2018 at around 6:00PM because of uncontrolled pain and difficulty transferring. V15 said R79 was now admitted to the hospital with some fractures that were not found during her initial emergency room visit October 29, 2018. R79's MDS (Minimum Data Set) dated October 1, 2018, showed R79 was severely cognitively impaired and required assistance of one staff member to transfer from surface to surface. The same MDS showed R79 was not steady when moving on and off the toilet and could only stabilize with staff assistance, and R79 had a history of falls. R79's fall assessments completed July 16, 2018, September 14, 2018, and October 29, 2018 all showed R79 at a high risk for falls due to confusion, disorientation and impulsivity.	S9999		

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S9999	Continued From page 6 R79's resident status sheet last reviewed October 2018 showed R79 to be confused, alert and forgetful and require assistance of one staff member for transfers. R79's current care plan with problem onset date of June 29, 2017 showed R79 to have a history of falling and poor standing balance. The same care plan showed intervention to monitor for changes in R79's condition that may warrant increased supervision/assistance and notify the physician. On November 1, 2018, at 10:42 AM, V10 CNA (Certified Nursing Assistant) said she works full time on R79's hall. V10 said R79 has been terribly confused lately. V10 said when R79 is taken to the bathroom staff have to stay with her because she will try and get up on her own. V10 said R79 would not be able to remember to use her call light even if it was explained to her because she could never remember to do that. V10 said, "If you put her there you better stay there." On November 1, 2018, at 10:55 AM, V11 CRA (Certified Rehabilitation Assistant) said R79 is not steady during transfers and ambulation and needs a walker, gait belt, and at least one assist and at times a second staff member to follow with a wheelchair. V11 said R79 was confused and forgetful and it takes several verbal cues and reminding to get her to understand what staff are asking to do. V11 said, "I would not leave her in the bathroom, she has to have someone with her for safety." On November 1, 2018, at 11:53 AM, V2 DON (Director of Nursing) said "they have a process that they use during clinical huddle and meeting	S9999		

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S9999	Continued From page 7 to try and figure out why a fall happened and to put updated interventions in the care plan. We try to do an immediate intervention. V2 said when R79 was sent back to the emergency room on October 30, 2018 and was found to have a fractured pelvis and a fractured right 10th rib. V2 said she received report that they are going to do pain management. V2 said these fractures are very painful and sometimes they send back with no physical therapy and just to do pain management and activity as tolerated. V2 said R79 is impulsive and does not retain information. V2 said we have to always be "on the lookout" for her because she is quick and we have to maintain a visual of her. V2 then said, "R79 has dementia and we have to remind her to use her call light because she forgets. She has dementia." On November 1, 2018, at 4:14 PM, R79 was observed back in the facility. R79 was lying in bed and calling out that she needed to use the bathroom. R79 was restless and was unable to follow the conversation when asked if she was experiencing pain. The hospital discharge instructions from R79's readmission to the facility on November 1, 2018 showed R79 is to be toe touch weight bearing on right extremity (unable to put full weight on right side). The assessment and plan history and physical from the hospital printed October 31, 2018 showed R79 to have an acute pelvic fracture, an acute compression fracture of the lower spine, an acute thigh and hip contusion, and an acute right rib fracture. The same discharge paperwork from the hospital showed R79's functional status at discharge as bed bound and a new narcotic pain control patch for pain control.	S9999		

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S9999	Continued From page 8 2. On October 30, 2018 at 1:14PM, R28 was sitting in an overstuffed recliner in the television lounge. R28 had a dressing to his left hand and a gait belt around his chest. On October 31, 2018 at 8:10AM, V3 LPN-Licensed Practical Nurse said, R28 wears the gait belt when sitting up, he tries to get up by himself. He has a history of falls. On November 1, 2018 at 8:10AM, V3 LPN-Licensed Practical Nurse said, R28 has a skin tear to his left hand. The hospice CNA-Certified Nursing Assistant left R28 sitting alone in his wheel chair while preparing him for a bath. He fell forward. I educated the CNA; R28 is never to be left alone when in the wheel chair. R28's MDS-Minimum Data Set dated August 13, 2018 shows, Brief interview for Mental Status 3-Serverly Impaired. R28's has multiple diagnosis including Non-Alzheimer's dementia, cataracts, glaucoma, or macular degeneration. The MDS: Functional status shows, Bathing Support: Total dependence Two persons physical assist. The facility's Incident list dated February 1, 2018 to October 30, 2018 shows, R28 has fallen 13 times. October 16, 2018, August 28, 2018, August 15, 2018, July 28, 2018, July 27, 2018, July 14, 2018, June 17, 2018, May 1, 2018, April 18, 2018, April 14 2018, March 24, 2018. February 20, 2018, and February 7, 2018. B	S9999		