STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING: _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

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S 000	Initial Comments Investigation of complaint number 1971775/IL110300.	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b)5) 300.1210d)6 300.3240a) 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 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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resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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.

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:

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 evidenced by:
Based on observation, interview and record review, the facility failed to monitor and provide assistance during transfer by not applying alarm monitoring device to promote resident safety.

This failure resulted in R1 sustaining 2 consecutive falls that resulted in injury to R1's right eye causing deterioration of vision.

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This applies to 1 of 3 residents (R1) reviewed for falls.

The findings include:

The POS (Physician Order Sheet) for the month of February 2019 showed that R1 has diagnoses that included but not limited to cognitive communication deficit, history of urinary tract infection, insomnia, hemiplegia with hemiparesis following cerebral infarction affecting left non-dominant side, heart failure, essential hypertension, atherosclerotic heart disease, coronary artery bypass graft, rheumatic aortic stenosis, atrial fibrillation, lack of coordination, abnormalities of gait and mobility and history of falling. R1 was a 92 year old and was admitted to the facility on 12/29/2018 from the hospital due to new onset of UTI (urinary tract infection).

The nurse's notes dated 12/30/2018 showed that R1 was able to walk with one person assistance but also prefers to use wheelchair.

The nurse practitioner notes dated 1/11/2019 showed that R1 had "markedly abnormal event monitor , with baseline NSR (normal sinus rhythm) with episodes of first degree AV (atrio ventricular block), with occasional PAC (premature atrial contraction) and unifocal PVCs (premature ventricular contractions) with 1 episode of 5 to 6 beat of NSVT (normal sinus ventricular tachycardia). The plan was for R1 to continue on Eliquis (anticoagulant/blood thinner).

The MDS (Minimum Data Set) dated 1/26/2019 showed that R1 scored 10 for cognition (moderately impaired); 1 for vision (impaired, sees large print, but not large print in newspaper/books); had mood of feeling down,

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depressed that occurs 2-6 days/2 week period; 3/2 (extensive assistance with 1 person assist) for bed mobility, bathing and locomotion on and off the unit. R1 scored 2/2 (limited assistance with 1 person assist) for transfer, walk in room and corridor, toilet use, and hygiene. The MDS also showed that R1 scored 2 (not steady, ONLY ABLE to stabilize with staff assistance for moving from seated to standing position, walking, turning around, moving on and off bed and surface to surface transfer (transfer between bed and chair or wheelchair). The MDS also showed that R1 scored 1 (impairment on one side) on upper and lower extremities. R1's mobility devices were walker and wheelchair. The active diagnoses documented on this assessment showed that R1 has history of falling, lack of coordination, and cognitive communication deficit. R1 was also identified on this assessment that she had a fall incident prior to this assessment.

The care plan dated 12/30/2018 showed that R1 was "at risk for fall secondary to unsteady gait." The interventions for fall prevention showed but not limited to the following: instruct on appropriate use of call light ; keep environment well lit and free from clutter; mobility monitor in place at all times; chair pad alarm at all times when up in wheelchair and bed pad alarm at all times when in bed.

On 3/19/2019 at 2:00 P.M., both V3 (Assistant Director of Nursing) and V4 (Nurse Consultant) had confirmed that the 12/30/2018 care plan were the interventions for R1's fall prevention.

The facility's incident report showed that R1 was found on the floor on 1/21/2019 at 10:30 P.M. and on 1/30/2019 at 11:05 A.M. These were 2 fall incidents in over a period of 9 days.

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The facility's incident report showed that on 1/21/2019 at 10:30 P.M., R1 was "found sitting on the floor beside her bed. There was a slight discoloration and bump on the left eyebrow". The report also showed that R1 stated that she "got up to go to toilet without asking for help and utilizing call light. The patient said she slid on the floor." The post fall assessment showed that R1's lack of safety awareness was considered one of the predisposing physiological factor of the fall. The predisposing situation factors for the fall showed: "trying to stand without assist; ambulating without assist; toileting needs; and unsafe transfer without assist."

The care plan revision for 1/21/2019 fall episode showed to "continue with current intervention; chair and bed alarm; reminded /education to use call light for help." There was also an "hourly rounding with staff to monitor patient." When V3 and V4 were asked during the survey, for the documentation regarding hourly rounding, they both stated that there was no documentation of hourly rounding. V3 and V4 were not able to explain whether reminding R1 to use call light would be applicable since R1 was assessed with moderate cognitive impairment. The bed and chair alarm was not mentioned on the post fall assessment whether it was applied or malfunction when R1 was found on the floor and the monitoring alarm device was not triggered. The revised care plan was not resident specific needs and interventions were not nonspecific.

On 3/27/2019 at 11:49 A.M., V5 (CNA; Certified Nurse Assistant), stated that on 1/21/2018, around 10:30 P.M., she heard someone screamed "Help, Help", coming from R1's room. V5 stated she immediately went to R1's room. V5

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added that she found R1 lying on the floor next to bed. V5 further stated that R1 did not pull her call light button and that R1 was not wearing a monitoring alarm, otherwise V5 would have heard the monitoring device. V5 also stated that R1 was not consistent using her call light button and is forgetful.

On 3/21/2019 at 3:45 P.M., V6 (Nurse) stated that she was called by a CNA that R1 was on the floor. V6 also stated that she immediately went to R1's room and found R1 lying on the floor. V6 added that R1 did not have an alarm monitoring device at time of the fall. V6 also stated that R1 hit her face on the floor and sustained skin discoloration on the left side of the face, bump on the left eyebrow and a skin tear on the elbow.

The facility's incident report dated 1/30/2019 at 11:05 A.M., showed that R1 had a fall witnessed by V8 (Occupational Therapist). The report showed "patient fell forward in the wheelchair and landed to the floor on her left side." ... (R1) remains with large bruise on left side of face from previous fall. " The report also showed that R1 was "forgetful and has lack of safety awareness."

On 3/21/2019 at 1:20 P.M., V8 stated that she was passing R1's room and saw R1 sitting in the wheelchair on 1/30/2019 at around 11:05 A.M.. V8 also added seconds later she heard a "thud "and saw R1 landed with face down to the floor. V8 also stated that R1 was not wearing a monitoring alarm device and there was no alarm triggered when R1 landed to the floor.

On 3/27/2019 at 11:00 A.M., V7 (Nurse) stated that she immediately went to R1's room when she was called that R1 fell to the floor on 1/30/2019. V7 added that R1 had no monitoring alarm device

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otherwise she would have heard the alarm. V7 also stated that V8 was there when she came to see R1.

The nurse's notes dated 2/7/2019 showed that R1 was discharged to another facility.

The admission assessment from another facility dated 2/7/2019 showed that R1 has multiple bruises on her body from previous fall. The following bruises were described as follows:
-left elbow 2.5 cm; x 2.0 cm. purple yellow
-right elbow 5.5 cm. x 2.5 cm. purple green
-left medial knee 1 cm. x 1 cm. purple
-left lateral knee 7.0 cm. x 6.0 cm purple
-right knee 4.0 x 8.0 cm purple
-left hip 2 cm. x 5.0 cm. purple
-left lateral thigh 5.0 cm. x 3.5 cm. bruise
-left side of face 16 cm. x 6.0 cm. purple

On 3/20/2019 at 4:00 P.M., R1 was seen at another facility. R1 still noted with faint bruise on the left side of face. R1 stated that she fell twice at another facility. R1 also added that she has always had blurry vision in her right eye due to a stroke. However, a few weeks after the fall, she felt a strong pain in her right eye and her blurry vision became worse. R1 also added that aside from the deteriorated vision of her right eye, R1 also had a bad headache. R1 further stated that she was taken to eye specialist and that she was told that she had bleeding in the left eye that seeped through to her right eye.

On 3/20/2019 at 3:50 P.M., V12 (Assistant Director of Nursing, current facility) stated that R1 did not have a fall at their facility.

The physician progress notes at other facility dated 3/6/2019 showed that R1 complained of

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decreased vision in the right eye with headache. An ophthalmology consult was ordered.

V10 (ophthalmologist) consultation report dated 3/7/2019 showed that R1 complained "my eyeball hurts and above my eye at my eyebrow and my cheek". The report also showed that R1's right eye has hyphema, increased intraocular pressure. It was also documented to see V11 (Retinal Specialist) ASAP (as soon as possible) for scan /ultrasound of the eyes.)

The documentation dated 3/7/2019 from V11, Retinal Specialist showed that R1 has vitreous hemorrhage of the right eye, hyphema of the right eye, ocular hypertension of the right eye and vitreous opacities of the left eye. V11's notes also showed that R1 "appears to have spill-over hemorrhage from the hyphema. It was discussed with (R1) and family about proceeding with surgery to clear this. However, given (R1's) history stroke history and age and poor visual potential in this eye, recommend observation. (V10) already has (R1) on a dilating drop which should help with headache and eye pressure."

On 3/21/2019 at 2:40 P.M., V10 stated that R1's hyphema/hemorrhage of the right eye was a spill over hemorrhage from the left eye. V10 also added that the hemorrhage/hyphema was caused from a traumatic injury like a fall. As V10 continued to state, that it was a delayed process to show the signs such as headache and worsened vision. V10 explained that the headache was caused from the increased intraocular pressure of the right eye. V10 also added that the hyphema was not caused from just plain rubbing of the eye but was a caused by a traumatic injury such as a fall and hitting the face. V10 also stated that R1 already has poor

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S9999	Continued From page 8 vision of the right eye due to history of stroke and this had made it difficult to detect the hyphema sooner until it was kind of late when R1 already showed accumulation of increased ocular pressure that had led to headache and that was when hyphema was identified. V10 also stated that when she examined R1 on 1/9/2019 for regular eye appointment, there was no concern identified. V10 also explained that it was only on 3/7/2019 that the hyphema was identified and it relate to R1's fall history that occurred after 1/9/2019. (A)	S9999		