STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004501	A. BUILDING: _____ B. WING _____	12/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments Complaint #2047351/IL126874- No deficiency Complaint #2046565/IL125965- F689 Licensure Findings:	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 300.610a) 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. 300.1210b) 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 resident to meet the total nursing and personal care needs of the resident. Restorative	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 measures shall include, at a minimum, the following procedures: 300.1210d)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. 300.3240a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interview and record review the Facility failed to provide progressive interventions to prevent accidents for 1 of 5 residents (R2) reviewed for falls in the sample of 10. This failure resulted in R2's fall requiring hospitalization for subsequent subarachnoid hemorrhage and death. Findings Include: R2's Physician Order Sheet (POS) dated July 2020 documents a diagnosis of Parkinson's Disease, and Dementia. R2's Minimum Data Set (MDS) dated 6/20/2020 documents R2 was moderately impaired cognition for decision making and has impairments of his upper and lower extremities. The MDS also documents R2's Balance was not steady but able to stabilize without staff	S9999		

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S9999	Continued From page 2 assistance moving from seated to standing position, on and off the toilet, and surface to surface transfers. R2's Quarterly Fall Assessment dated 6/10/2020, documents, "intermittent confusion, 1-2 falls in last 3 months, ambulatory, balance problems when standing, Total score of above 10 represents high risk (R2) scored a 16. (R2) transfers independently." R2's Care Plan with an onset date of 6/6/2020 documents "(R2) is at risk for injuries related to falls, related to a history of falls 10/19/2019, 12/16/2019, 1/31/2020, 2/11/2020, 3/20/2020, 3/22/2020, 4/20/2020, and 7/8/2020, High score on his fall risk assessment, weakness, cataracts and Parkinson's Disease," R2 has had 8 falls in the facility since 10/2019. On 12/1/2020 at 9:28 AM, V14, Certified Nursing Assistant (CNA), stated, "(R2) was constantly confused, he could never sit still and was always wandering around the facility. He was frail, and he had falls in the past. I don't really remember much about him and his falls. He could be redirected if he was close to a door or something, but he was very confused at times and could never remember anything you told him. (R2) was a fall risk and had several falls." On 12/1/2020 at 9:32 AM, V12, CNA stated," (R2) had dementia and Parkinson disease, so he was very confused. He had his good days and his bad days. Overall, he could not remember things and was very forgetful. On his bad days, you could not really rely on him to obey or listen to you. (R2) had several falls while he was here." 1-R2's Nurses Notes dated 1/31/2020	S9999		

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documents, "Resident found by staff laying on back on floor next to bed with head near bed frame. Resident states he was standing up to go to the bathroom and lost his balance. Also states that he bumped the back of his head. Skin inspection performed with 3- cm (centimeter) x 2 cm slightly reddened area to back of skull."

R2's Incident Report, date of incident 1/31/2020 at 8:07 AM, document, "Resident found by staff laying on back on floor next to bed with head near bed frame. Resident states he was standing up to go to the bathroom and lost balance. Intervention: 'Keep my pathways clear and clutter free,' Root Cause, 'Resident attempted to stand from bed and lost balance trying to move past bedside table. Unable to regain balance then fell to the floor'."

R2's Care Plan date entered 1/31/2020 documents, "Make sure all my pathways are clear and clutter-free."

2-R2's Nurses Notes on 2/11/2020 at 6:29 PM, documents, "Found sitting on bottom, laughing in front of recliner. Intervention, 'Place gripper tape in front of recliner.' We think he slid out of his recliner."

R2's Care Plan with an entered dated of 2/19/2020 document, "I have gripper tape placed in front of my recliner to assist me with transferring."

R2's Incident Report, dated 2/11/2020 at 6:13 PM, document, "Found on his bedroom floor sitting on his buttocks, legs extended out in front of him. He was laughing denies hitting his head, no complaint of pain and or discomfort. Intervention, monitor blood pressure at every

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shift, related to postural hypertension. Encourage to ask for assistance, due to bouts of weakness. Ensure room and path is clutter free. Root Analysis, Increased paranoia and agitation, and refusal of medications noted on shifts prior to fall. Resident stood up from recliner and lost balance landing on the floor."

3-R2's Nurses Notes dated 3/20/2020 at 2:45 PM, document, "Patient was in a hurry to get onto the toilet related to diarrhea. Patient feet got tangled underneath him and he fell backwards through the doorway of the bathroom into (another room)."

R3's Incident Report dated Incident occurred 3/20/2020 at 10:15 AM, documents, "Patient was in a hurry to get onto the toilet due to diarrhea. Patient feet got tangled underneath him and he fell backwards through the doorway of the bathroom into (next room). Intervention: Resident needing to use toilet and ambulated in a hurry to bathroom. Lost balance while in bathroom and fell to ground. Resident hit head."

R2's Care Plan entered on 3/20/2020 documents, "I am independent in my room, but I still require cues for toileting. Sometimes I wait too long to go to the bathroom and rush too quickly. Please remind me to toilet every 2 hours as needed."

4-R2's Nurses Notes dated 3/22/2020 at 11:15 AM, document, "Patient fell attempting to get up from his recliner. Unknown if he hit his head. No injuries noted."

R2's Incident Report, dated 3/22/2020 at 11:15 AM, document, "Patient fell while attempting to get out of his recliner, No injuries noted, range of motion normal." "Intervention, Pathways clear and

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clutter free. Root Analysis, Patient has a history of falling, while attempting to maneuver out of recliner in room. While attempting to stand, residents left leg stand of chair in highest position and lost balance." This intervention is the same intervention that was documented for a previous fall on 1/31/2020 for R2.

R2's Care Plan entered on 4/5/2020 documents, Care Plan, "My recent fall involving my recliner have had my leg rest up on my recliner while I attempted to transfer. Please remind me to lower my leg rests and give me positive encouragement when I successfully transfer with my recliner."

5- R2's Nurses Notes dated 4/20/2020 at 2:25 PM, "staff called writer to room. CNA in room giving care to resident roommate. Resident was standing next to recliner with walker, resident states he became dizzy, lost his balance and fell hitting his head on bed. no injuries noted. Range of Motion within normal limits. Neuro checks initiated. Resident denies any pain or discomfort. Resident encouraged to call for assistance with transfers."

R2's Incident Report dated 4/20/2020 at 1:51 PM, "Resident became dizzy while staff was in room and lost balance striking head on bed. Intervention, monitor blood pressure every shift related to hypotension, and dizziness while standing. Root Analysis, Resident stood up too quickly from bed and became dizzy, Unable to catch self before falling to the ground."

R2's Care Plan entered on 4/23/2020 document, "Encourage me to remain sitting for a few minutes before attempting to stand up."

6- R2's Nurses Notes dated 7/8/2020 at 9:05 AM,

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document, "Patient fell backwards in his room hitting his head. CNA was in the room but back turned caring for another patient. Bedside table under his feet. Patient unable to respond to verbal commands or open eyes during first 90 seconds. Then patient opened his eyes and yawned. Swelling and bruising noted to the back right of scalp and Skin tear to the LFA (left frontoanterior). MD (Medical Doctor) in house and aware. Send to ER (Emergency Room) for Head CT (Computed Tomography)."

R2's Incident Report for 7/8/2020 at 9:05 AM, documents, "Patient found on the floor per CNA after hearing a loud crash behind her. STAT (as soon as possible) call brought this nurse to patient's room where patient was found on the floor on his back. Eyes closed not responding to verbal or physical cues. Pupils not responding to physical light. Approximately 4 cm hematoma noted to the back of the scalp towards the right side above the occipital bone. Medical Doctor in house came into room and determined patient needed to be sent to the Emergency Room for Head CT. Call placed to 911. Patient started to verbally respond and blink his eyes on his own after approximately 60 seconds. When EMT (Emergency Medical Technicians) arrived, patient was talking per norm and joking about flirting with the cute nurses at the hospital. Interventions: Keep pathways clear. Encourage resident to lower foot rests while attempting to get out of the chair. Root Cause: Resident tripped over lower leg of bedside table and fell to ground striking head." This is the same intervention documented for 1/31/2020 and 3/22/2020 and on both of these occasion R2 hit his head during these falls. No new intervention was documented.

On 12/2/2020 at 12:15 PM, V12, CNA, stated, "I

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was in (R2's) room giving care to his roommate when he fell backwards back in July of this year. My back was turned to him and I heard a big thump from where he had fell. He was on his back. I did not see him fall. I only heard it. (R2) was independent for transfer in his room and he could transfer himself. He had dementia and Parkinson's and he had good days and bad days. At times he was confused, and he would shake a lot and things like that related to his Parkinson's Disease. Depending on the day, because it varied whether (R2) was compliant and asked for help. Sometimes, (R2) could ask for help when he needed help and sometimes, (R2) just could not remember."

On 12/2/2020 at 12:40 PM, V11, Licensed Practical Nurse (LPN), stated, "I remember that day and the intercom telling the nurse to go to (R2's) room back in July. When I got into (R2's) room and I went there immediately, (R2) was on the floor and he was out like a light. (V12) had his head in her lap and we were softly telling him to wake up and wake up. He had a very large lump on his head and (V13, Medical Doctor) was in the building and he heard the code too and we both got there about the same time. (V13) looked at me and told me to send (R2) out. A few minutes later, (R2) woke up and was joking. We sent him out to the hospital, but he never came back. (R2) had dementia and Parkinson's and he had days of confusion some days were better than other days. There would be some days that you would tell him something and he would forget quite easily. You never knew what you were going to get because some days he could be okay and other days he was very confused."

R2's Nurses Notes dated 7/8/2020 at 9:30 AM, document R2 was sent out to the (hospital) on

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7/8/2020. "Emergency Medical Technicians here, Patient transferred safely onto stretcher, report given. Patient speaking now and cracking jokes."

R2's Hospital Records dated 7/8/2020 at 10:24 AM, document, "Patient sent to ED (Emergency Department) via EMS (Emergency Medical System) for an unwitnessed fall to back of head. This occurred in the bathroom of his memory Care Center. It was unclear whether he had loss of conscious. EMS report positive loss of conscious however nursing home staff in their phone call to ED RN (Registered Nurse) stated no loss of conscious."

R2's CT Scan dated 7/8/2020 documents, "there is acute subarachnoid hemorrhage (brain bleed) along the right cerebral convexly measuring up to 10 mm (millimeters) in thickness. Right anterior and posterior parafaicne subdural hematomas. Subarachnoid hemorrhage along the sylvian fissure and right frontal and temporal lobes. Mild subfalcine shift to left, proximally 4 mm."

R2's Death Certificate dated 7/11/2020 documents cause of death fall at ground level, subarachnoid hemorrhage.

The Facility's undated Accident/Incident Fall Report Policy documents, "The incident report is filled out each time an incident occurs. The root case analysis is also filled out, signed off by a charge nurse in an effort to know what happened to cause the accident and also to help staff find preventative approaches to prevent further accidents."

A