STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003305	A. BUILDING: _____ B. WING _____	C 08/18/2017

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FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

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S 000	Initial Comments Complaint investigation #1714931/IL96183-F323	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 resident to meet the total nursing and personal care needs of the resident. 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. (Section 2-107 of the Act) These Regulations are not met as evidenced by: Based on interview and record review the facility failed to adequately supervise a new admission	S9999		

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with a history of falls, and have individualized interventions in place to safely care for a resident at risk for falls. The facility failure resulted in R4 sustaining a fracture to her recently repaired left hip, and R4 required a second surgery. This applies to 1 of 3 residents (R4) reviewed for falls in the sample of 5.

The findings include:

R4 was admitted to the facility on July 31, 2017 after a fall in her apartment. R4's face sheet shows diagnoses of pathological left hip fracture, hypokalemia, heart failure, chronic obstructive pulmonary disease and unspecified physical fracture of upper end of humerus of left arm. The nursing discharge/transfer hospital communication form dated July 31, 2017 shows R4 to be alert but confused with more confusion noted at night. R4 was a fall risk at the hospital and was using a bed alarm.

The facility's fall log for August 2017 shows R4 slid out of her recliner on August 1, 2017 at 6:30 AM (the next morning after admission) and fell a second time at 11:30 PM (17 hours later) that same day.

On August 18, 2017 at 10:00AM, E2 DON (Director of Nurses) said R4's daughter brought to the facility a pink incontinent pad for her mother to use. E2 said the facility does not use these in a recliner as they have been identified as a risk for falls from the recliner. E2 said she was not aware how long this pink incontinent pad was in R4's recliner but she would have preferred it would have been removed. E2 said R4 was placed on the yellow dot or alternate call system after her first fall just so staff could have more frequent observations of her. E2 said there is no

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documentation to show how often R4 was observed. (The policy for the alternate call system shows it is used for residents that need an alternate source of monitoring for needed assistance. Part of the procedure from this policy shows all staff will be instructed to look into the open room to check the resident as staff passes by the door. Residents will be checked approximately every 30 minutes).

On August 16, 2017 at 11:05 AM, E5 CNA (Certified Nursing Assistant) said R4 was very confused. R4 would keep trying to get up and down from her recliner. R4 didn't know where she was and would fidget and pick at her incontinent brief.

On August 16, 2017 at 4:50 PM, E6 LPN (Licensed Practical Nurse) said R4 was alert but had periods of confusion. E6 said R4 at times thought she was at work as a nurse at a hospital and had forgotten she had a broken hip. E6 said R4 fell August 1, 2017 at 11:30 PM; from her recliner a second time after trying to get up on her own. E6 said R4 never slept in her bed because it was more comfortable for her to sleep in the recliner. E6 said R4 did not have a chair alarm until after the second fall.

On August 18, 2017 at 9:30 AM, Z4 (R4's Orthopedic Surgeon) said the second fracture of the left hip is definitely a result of the falls R4 had while at the nursing facility.

On August 16, 2017 at 10:30 AM, Z1 (R4's family) stated, "R4 was confused at the hospital so I was with her when she was admitted to the facility, I did not feel she was aware of what all was going on. I was worried about her overnight so I asked E2 DON (Director of nurses) and E3 (Resident

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Services) if I could pay for a sitter or spend the night and was told no. She fell for the first time at 6:25 AM on August 1, 2017, I went to see her that day and she was even more confused. I told the nurse about the confusion. She fell again that night at 11:30 PM, slid out of her chair again. I was called and told about it and that there were no injuries. The next morning when I was visiting her she moved her leg and I heard a pop and some crackling noise. I got the nurse and demanded an x-ray. Her left leg was broken around her prosthesis. She went back to the hospital but had to be transferred to another hospital that could handle the repair of this type of fracture".

On August 16, 2017 at 9:50 AM, E1 (Administrator) stated, R4's daughter mentioned something about staying the night with her mother, I encouraged her to go home. "The residents rest better when family are not here."

The Nurses' Admission Record for R4 shows nothing documented in the condition on admission regarding alertness and orientation.

R4's undated care plan shows that R4 required extensive assistance with weight bearing support, had a history of falls with fractures, and required a two person assist for transfers. The care plan also shows R4 had full weight bearing of her lower extremities and no weight bearing to left arm. The care plan does not show any interventions related to the recliner for R4 after the two falls from her recliner.

The facilities fall risk assessment tool dated July 31, 2017 shows R4 to be at high risk for falls. The cognition section of the assessment tool shows R4 to have a lack of understanding of one's

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physical and cognitive limitations.

The nursing progress note dated August 1, 2017, at 6:25 AM, shows, "Resident attempted to get up from recliner and slid out onto floor. Call light was within reach but not on. Resident educated on use of call light for assistance." The incident report completed by the facility after this fall shows her condition prior to the fall to be confused.

The nursing progress note dated August 2, 2017 at 3:30 AM shows, at 5:00PM on August 1, 2017 R4 was alert with periods of confusion. At 11:30 PM that same note shows R4 had slid out of her recliner while trying to get up on her own. The note goes on to show resident was disoriented to where she was, thought she was at home. R4 was reoriented to time of day, date and recent hip fracture and surgery. E6 LPN (author of this note) stated and documented confusion for R4 and this is why she placed R4 on a chair alarm after the second fall.

The nursing progress note dated August 2, 2017 at 7:30 AM, shows R4's daughter told the nurse she heard a pop from R4's hip. The nurse documented the left leg was shorter than the right leg.

The x-ray report dated August 2, 2017 shows acute periprosthetic fracture (fractured bone around a surgical hip implant) involving the lateral femoral cortex of the left leg. (Same leg originally fractured and just repaired)

The facilities Fall Reduction and Prevention Policy dated May 2017 shows the purpose is to reduce the risk of injury acquired as a result of resident falls. Interventions will be put into place

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S9999	Continued From page 6 based on the total fall risk score of the fall risk assessment tool and individualized for that resident to reduce the risk of injury from a fall. The policy also shows in the event of a fall nursing personal will initiate an immediate intervention based on nursing judgment. Immediate interventions are to be documented on the incident report and in the resident's clinical record. Interventions may include but are not limited to the following: A. alternate call system, B. monitors/alarms, C. alternate transportation, D. room placement, E. environmental changes, F. evaluation/treatment from therapy, G. hip protectors, and H. night lights. (A)	S9999		