STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016786	A. BUILDING: _____ B. WING _____	11/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CREEK NRSG & REHAB CTR	777 DRAPER AVENUE JOLIET, IL 60432

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S 000	Initial Comments Annual Licensure and Certification Survey Statement of Licensure Violations	S 000		
S9999	Final Observations 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 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. Restorative measures shall include, at a minimum, the following	S9999	Attachment A Statement of Licensure Violations	

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procedures:
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 requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to provide assistance to a resident identified as high risk for falls and needing two person physical assistance during transfer to promote resident safety.

This applies to 1 of 4 residents (R1) reviewed for falls in the sample of 17.

This failure resulted in R1's fall during one staff assisted transfer. R1 was sent to the hospital and was diagnosed with right distal femur fracture.

The findings include:

R1 was admitted to the facility on November 3, 2016 with multiple diagnoses which included hemiplegia and hemiparesis following

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cerebrovascular disease affecting right dominant side, muscle weakness, epilepsy and history of falling based on the resident's diagnoses list.

The facility initial & final reportable report showed that R1 had a fall incident on January 26, 2017 at 3:30 PM. The report showed, "At approximately 03:30pm the resident CNA (Certified Nursing Assistant) was using her gait belt to transfer the resident from the wheelchair to the toilet. Upon transfer resident knees buckled, resident lost her balance and the CNA lowered the resident to the floor. CNA immediately called for the nurse. Upon nurse observation, resident right knee was swollen and resident complained of pain." The report showed that the physician was notified of the fall incident with order to send R1 to the hospital ER (emergency room) for evaluation. The same report also showed that R1 was diagnosed and hospitalized with diagnosis of distal right femur fracture.

R1's quarterly MDS (minimum Data Set) dated January 18, 2017 showed a BIMS (Brief Interview for Mental Status) score of "14" which meant that the resident is cognitively intact. The same MDS also showed that R1 would require extensive assistance of two or more staff members' physical assist for transfers and toilet use.

R1's current MDS dated October 21, 2017 showed a BIMS score of "13" which meant that the resident is cognitively intact. The same MDS also showed that R1 would require extensive assistance of two or more staff members' physical assist with transfers and toilet use.

R1's fall risk assessment dated November 4, 2017 showed a score of "14," which meant that the resident is at high risk for fall.

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R1's current care plan initiated on November 21, 2016 (in effect on January 26, 2017) regarding falls showed that R1 "Is at increased risk for injury R/T (related to) falls due to history of falls, dementia, episodes of syncope/seizures, incontinence and CVA (cerebrovascular accident) with right hemi." This fall care plan's goal is for R1 to remain free from serious injury related to fall

On November 7, 2017 at 9:45 AM, R1 was in bed, alert and oriented, watching television. R1 stated that early this year she broke her right leg after a fall. Per R1, she was attempting to transfer from the toilet to her wheelchair with staff assistance. During the process of transfer, she was trying to reach for the bathroom grab bar but missed it and fell on her right knee on the floor. According to R1 when she fell and landed on her right knee, "I heard it pop up and I was in severe pain." R1 stated that during this transfer, there was only one staff assisting her and that no gait belt was used. Per R1 the staff was just holding her by her arm when she fell on her right knee.

On November 7, 2017 at 10:55 AM, during morning care observation, R1 stated, "Look, this is the scar from the surgery I had after my fall." R1 was pointing on her right femoral area.

On November 7, 2017 at 11:07 AM, during transfer observation E12 (CNA) applied a gait belt around R1's waist. R1 was shown the gait belt and was asked, if a similar belt device was applied on her when she had the incident of fall. R1 responded, "No, she did not put any belt on me." During this observation and interview, E4 (CNA) and E13 (nurse unit manager) and E12 were present.

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On November 7, 2017 at 11:28 AM, E4 stated that she was the staff assigned to R1 on January 26, 2017 when the resident had the fall incident. Per E4 she was assisting R1 with transfer from the toilet to the wheelchair using a gait belt on January 26, 2017 at around 3:30 PM. During this attempted transfer, E4 stated that she positioned herself in front of R1 with one of her leg positioned in between R1's legs for stability, then she held the gait belt on both sides, to assist R1. Per E4, R1 stood up and was about to turn when R1's knee buckled so, she slowly sat R1 on the floor and activated the call light for help. According to E4, R1 complained of pain after the resident sat down on the floor. During the same interview E4 stated that when the incident happened she was new to the facility and was not aware that R1 needed a two person assist for transfers and toilet use.

On November 8, 2017 at 1:17 PM, E17 (nurse) stated that he was the nurse on duty when R1 had the fall on January 26, 2017. Per E17 he does not remember a lot of details pertaining to the fall. E17 stated that the only thing he remembered is that when he assessed R1 after the fall, the resident was complaining of pain on the right knee during movement and when the area was touched. E17 also stated that he remembered that the right knee was also swollen.

Review of the facility's undated policy and procedure regarding, "Limited lifting resident handling" showed, "Use of gait belt for all physical assist transfers is mandatory."

R1's emergency room records dated January 26, 2017 showed under history of present illness showed, "Location: Right knee. The character of

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S9999	Continued From page 5 symptoms is pain and swelling. The degree at present is severe. The exacerbating factor is movement. The relieving factor is none." R1's hospital records dated February 1, 2017 showed that the resident was diagnosed with right distal femur fracture and an intramedullary nailing was performed. (A)	S9999		