STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002489	A. BUILDING: _____ B. WING _____	C 09/25/2018

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S9999	Final Observations Statement of Licensure Violation: 1 of 1 Violation 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to implement effective interventions and provide supervision to prevent falls for 2 of 3 residents (R1, R2) reviewed for falls in the sample of 8. This failure resulted in R2 having 4 falls with injuries requiring her to be sent to Emergency Room (ER) for treatment.	S9999		

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Findings include:

1. On 9/20/18 at 9:35 AM, R2 was sitting in her wheelchair in the hallway outside of her room. R2's foot pedals were on her wheelchair while R2's feet were on the ground. R2 was moving her bottom forward in the seat, trying to stand up while the foot pedals were down. No staff were in the area to supervise her.

On 9/20/18 at 10:10 AM, R2 was sitting in her wheelchair. R2 was propelling the wheelchair with her arms. R2 left the activity room and went as far as she could go on the carpet until she came to the strip on the carpet leading to the wood floor. R2 was unable to get the wheelchair across the strip on the floor. R2 put her feet on the floor and the foot pedals were down, trying to push her over the strip while she is leaning forward. V2 Director of Nurses (DON) walked past R2 and didn't see her struggling to move the wheelchair or that the foot pedals were down with her feet on the floor.

R2's Electronic Medical Record documents in part, R2 was admitted to the facility on 11/1/17 with diagnosis of, Hypertension, Schizoaffective disorder, insomnia, Anxiety disorder, Anemia, Abnormal Posture, Bipolar disorder, Chronic Kidney disease, Cognitive communication deficit, Difficulty walking, Dysphasia, History of Falls, Hyperlipidemia, Major Depressive Disorder, Muscle weakness, Myocardial Infarction and Lack of Coordination.

R2's Minimum Data Set (MDS) dated 6/19/18 documents, R2's Brief Interview of Mental Status (BIMS) score was10, indicating moderately impaired cognition. R2's MDS documented she

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required extensive assistance from two staff persons for transfers. The MDS documented she required extensive assistance from one staff person with locomotion on and off unit and walking.

The facility's fall log from March 2018 through September 2018 documented R2 had fallen eleven times in the past six months. R2 has had 4 falls with injuries. The Log documented on 9/14/18 she sustained a laceration to her forehead. The Log documented on 8/25/18 she sustained a laceration to her forehead. The Log documented on 4/23/18 she sustained a laceration to her face and on 4/20/18 a laceration to her head.

R2's Fall Occurrence note dated 4/20/18 documents in part, "Resident was found by maintenance director on floor, resident was laying on right side with approximate 15-30 cc (cubic centimeters) of frank red blood around head. Resident was assessed for injury to lower and upper extremity. No injury noted. No complaints of neck pain, only head pain. Resident is very uncooperative with assessment and neuro checks. Injuries observed, Laceration to right forehead approximate 2 cm (centimeters). Approximate 15-20 cc blood loss, pressure was applied. Bleeding was stopped easily. Actions taken Sent to local ER (Emergency Room) for evaluation of head trauma from fall. Intervention: resident is uncooperative and will not usually redirect."

R2's Progress notes dated 4/23/18 at 7:00 AM, documents, "Narrative: lab tech informed writer that res had dried blood all over floor and on hosp (hospital) gown writer went in room at 0609 res (resident) sitting in w/c (wheelchair) by bathroom

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in clean clothes no blood on hands dried blood noted on lips small amt (amount) active bleeding to laceration under lower lip and deep laceration under chin oral cavity with dried blood and dk (dark) areas posterior teeth and roof of mouth Hosp gown on bathroom floor with mod (moderate) amt (amount) dried blood and areas of dried blood on bedroom floor." Immediate Action Taken, "Description: All areas assessed, noted need for sutures to laceration on chin, to ER for evaluation."

The facilities Root Cause Analysis of R2's fall on 4/23/18, "Standing up in room. Intervention and care plan updated, Environmental check of the room around closet."

R2's Progress notes dated 8/25/18 documents in part, "Resident observed to be on the floor. Resident mildly responsive to tactile stimulus. Resident states 'I was in my wheelchair when I fell to floor. States 'I am not hurt'. Resident has small laceration to lateral lobe of head. Laceration treated via paramedics, called post fall. Unable to complete vital sign capacity due to resident physical composition at this time. Resident is side lying with limp stance and mildly responsive. Resident responsible party notified. Resident transported via EMS to local emergency room for evaluation."

The facilities Root Cause Analysis of R2's fall on 8/25/18 which was dated 8/27/18 documents, "Root cause of the fall fell out of wheel chair onto the floor." Interventions and care plan updated: "Monitor laceration till healed, offer to lay down after every meal."

R2's Progress Note dated 9/14/18 at 12:07 PM, documented, "Resident lying in the hallway at

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11:20 AM. Legs were stuck under the wheelchair with the wheels up in the air. Resident has a large laceration to her forehead/scalp on the left side. Resident was helped out of the wheelchair and pressure was put to her forehead. Resident had complained of pain to both knees and lots of pain to her right hip area. Ambulance service was called right away. They arrived at 11:30. resident left the facility with them at 11:55 AM. Power of Attorney (POA) was notified."

R2's Emergency Room Final Report, dated 9/14/18, documented "Physical Exam includes Head: 3 cm jagged laceration to left forehead repaired with sutures. Plan: Hospitalist admitted resident due to altered mental status, confusion, (she thinks its 1978). Resident discharged back to facility on 9/17/18."

The facilities Root Cause Analysis of R2's fall on 9/14 18, which was dated 9/17/18 documents. "Leaning forward, fell out of wheel chair." Interventions and care plan updated with, "Med review, lay her down when she is leaning forward, have her evaluated for psych facility upon return."

R2's Care Plan dated 7/2/18 documents in part. Focus: I am at risk for fall/injury related to wandering/poor safety awareness, insomnia, anxiety disorder, anemia, Bi-Polar, History of falls and hypertension. I will put myself on the floor at times. Interventions: 12/26/17 Call light within reach and area free from clutter. Draw labs as per MD orders. Keep personal items within reach. Observe for any signs and symptoms of any drugs that can cause gait disturbance, orthostatic hypotension, weakness, sedation, lightheadedness, dizziness, change in mental status. 1/15/18 Offer me painting, I like to paint. Lowered rod in closet and removed my summer

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clothing. 2/12/18 Dycem replaced in wheel chair. 2/7/18 Report all behaviors to behavioral care and for them to evaluate. 2/22/18 Increased staff supervision and refer for psych eval (evaluation) and possible inpatient stay. 3/16/18 Environmental check and behaviors evaluated. 3/27/18 Encourage me to wear shoes, I do not care for the grippy socks due to the feel of them. 4/9/18 Low bed put into place. 4/20/18 Environmental check of the room and around the closet. 5/23/18 Staff to increase offering me to toilet more frequently. 6/15/18 Offer to lay me down after lunch. 6/25/18 Dycem in wheelchair. 8/20/18 Behavioral Care to see at next visit. 8/21/18 Speech Therapy to evaluate. 8/27/18 Offer to lay me down after breakfast and supper. 9/10/18 Therapy to screen. 9/27/18 Medication review, offer to lie me down when I am leaning forward in the wheelchair and evaluation for placement in psych facility upon my return. R2's Care plan does not document anything about removing foot pedals to R2's wheelchair when she propels herself.

On 9/20/18 at 12:35 PM, V5 Licensed Practical Nurse (LPN) stated, "R2's fall was not witnessed by staff, R2's foot pedals were on the wheelchair when she fell on 9/14/18, she was on the floor in the hallway, her knees were on each foot pedal, her feet were under the wheelchair, she had a laceration to her forehead and was bleeding. V5 stated, "I wondered why (R2) had foot pedals on her wheelchair when she was propelling herself."

On 9/20/18 at 2:40 PM, V13 Occupational Therapist stated, "Foot pedals should not be on the wheelchair if the resident propels herself. (R2) is a special case, some days she propels herself all around, other days she doesn't propel herself at all. The staff should take the foot pedals off

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S9999	Continued From page 7 when she is alert and propelling herself." On 9/20/18 at 3:05 PM, V14 Certified Nurse Aide (CNA) stated, "No one has trained me about when to use the foot pedals with (R2)." The facility Policy and Procedure for Fall Prevention Program dated 11/28/12, revised 11/21/17, documents in part, "Purpose: To assure the safety of all residents in the facility, when possible. The program will include me which determine the individual needs of each resident by assessing the risk of falls and implement appropriate interventions to provide necessary supervision and assistive devices are utilized as Quality Assurance Programs will monitor the program to assure ongoing effectiveness. Guidelines: The Fall Prevention Program includes the following components: *Methods to identify risk factors *Use and Implementation of Professional Standards of Practice *Communication with direct staff members *Adherence to manufacturer's recommendation in use of alarm and medical devices and equipment *Care Plan incorporates: *Identification of all risk/issue *Interventions are changed with each fall, as appropriate and Preventative measures." 2. The MDS dated 8/16/18 documents R1 to be cognitively intact with a BIMS score of 15. The MDS documents R1 to require extensive assist of two staff for transfers and extensive assist of one staff for locomotion on and off unit. The MDS identifies R1's balance as "not steady, only able to stabilize with staff assistance" for seated to standing, turning around, on/off toilet and surface to surface transfers. The Care Plan dated 8/16/18 documents R1 to be	S9999		

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at risk for falls due to hypertension, edema, congestive heart failure, obesity and left knee pain in part. The goal documents R1 will sustain no serious injury from falls until next review with interventions for staff to "remind her to lock her wheeled walker prior to sitting down (4/18/18), anticipate and meet needs, "be sure call light is in reach and encourage to use it for assistance, and ensure appropriate foot wear"

On 9/20/18, the Incident/Accident log has documented 6 falls for R1 since 7/13/18.

R1's Progress Note dated 7/13/18 document R1 slid out of her recliner as she was reaching for something and had a pillow behind her that cut down on sitting space in the chair. There was no revision made to the care plan as a result of this fall.

On 7/16/18 at 4:17 AM, R1 Progress Note documented R1 slid out of bed trying to get up to go to the bathroom. The root cause was identified and an intervention dated 7/17/18 was added to the care plan for staff to encourage not placing pillow in recliner and offering non-skid socks. An Occupational evaluation was also recommended. This fall occurred from the bed not the recliner chair as the intervention suggests and there is no information as to whether or not she had appropriate foot wear on as is included in her care plan.

On 7/18/18 at 12:10, R1's Progress Note documented again "sliding from her easy chair onto the floor." There was a note that R1 had grippy socks on. There was no new revisions and/or interventions added into the falls prevention plan following this fall and no information as to whether R1 had the pillow to her

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back at the time or not.

On 7/25/18 at 11:00 AM, R1's Progress Note documented R1 to be on the floor in front of her chair with the wheeled walker next to her in an unwitnessed fall. The note documents R1 was trying to get something out of the refrigerator. The note documents staff applied shoes. The root cause was identified as "attempted self transfer" but fails to address whether she had on shoes or not at the time of the fall.

A Fall Interdisciplinary note dated 7/26/18 documents the cause of the fall to be attempted self transfer with the intervention being to "put up reminder signs in the room to call, don't fall." However, it doesn't address the fact that she again had no shoes on and doesn't indicate whether or not she had grippy socks on at the time of the fall as is listed as an intervention in her care plan.

On 9/4/18 at 1:00 PM, R1 was documented in the progress notes as being up and ambulating without staff assistance when she fell and slid to the floor. The intervention is to make sure she has staff with her when ambulation. The root cause was identified as an "attempted self transfer." The care plan documents an intervention to do "Orthostatic blood pressure times 3 days 9/4/18" since the Falls - Initial Occurrence Note dated 9/4/18 documents R1 stated "when she stood up she got light headed and dizzy and slid down to the floor."

On 9/10/18 at 9:15 AM, the progress notes document R1 attempted to go to the bathroom and fell. The care plan reflects a new intervention dated 9/11/18 that reads "remind her of signs in room to call, don't fall, medication review and

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S9999	Continued From page 10 encourage to ask for assistance." No new interventions were implemented as a result of this fall. On 9/25/18 at 8:45am, R1 was sitting on the edge of her recliner which was positioned against the wall in her room. She had a pillow to her back and had worn grippy socks on. There was a cloth incontinent pad under her covering the cloth recliner seat. R1's wheeled walker was in front of her. The television was adjacent to her, right against the wall in the corner causing her to sit crooked in the recliner in order to see the television. R1 did not have a call light within reach as it was on the bed across the room. R1 stated she is able to ambulate about her room by herself without assistance of staff and acknowledged that her television was a little difficult to see from where her chair is located. R1 stated she does get into her refrigerator for sodas which are located under her television. (B)	S9999		