STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

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S 000	Initial Comments Annual Health Statement of Licensure violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 4) 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:
4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.
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 supervision and assistance to a resident totally dependent for toileting for one of three residents (R42) reviewed for falls. These failures resulted in R42 self-transferring to the toilet, losing balance and falling which resulted in R42 sustaining a left wrist fracture.

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Findings include:

The facility's Falls Management Program policy dated 07/2017 documents, "Muscle weakness and walking or gait problems are the most common cause of falls among nursing home resident. A "Fall" refers to unintentionally coming to rest on the ground, floor, or other lower level. An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. Resident's Transfer and Mobility: Know which residents need assistance during transfers and walking. Give help when needed. Provide toileting, food, drink, and activity based on the resident's individual schedule. Check the resident often."

R42's MDS (Minimum Data Set) Section C Cognitive Status documents R42 is cognitively intact, and Section G Functional Status, documents R42 is totally dependent on two staff for transfers and toilet use. This same MDS documents R42 is continent of bowel and bladder.

R42's current Fall Care Plan documents: 6-7-17 Staff will offer to take R42 to the bathroom after meals and every two to three hours. 6-13-18 R42 requires the mechanical lift for all transfers and no longer ambulates.

R42's current Kardex (Nursing Medical Information Document) documents: Toileting offer the bathroom every two hours.

The facility's Nursing Unit Assignment Schedule dated 8-6-18, documents V4 (Licensed Practical Nurse/LPN) and V5 (Certified Nursing Assistant/CNA) were the two staff scheduled on

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S9999	Continued From page 3 8-6-18 from 6:00 PM to 10:45 PM to care for resident's on R42's hallway, including R42. R42's Incident Report dated 8-6-18 at 8:31 PM, documents, "(R42) yelled out for help. CNA found resident on the floor in the bathroom. (R42) on her back. Left wrist hanging at unnatural position. Appears to cause (R42) significant pain. Skin tear noted on the left wrist. (R42) could not hold urine any longer attempted to put self on toilet. Slipped. Sent to emergency room for evaluation and treatment due to pain and possible fracture to the left wrist." R42's Left Wrist X-Ray dated 8-6-18, documents, "Impression: Distal radial transversely oriented impacted fracture with ulnar and dorsal angulation of distal fracture fragments." V5's (CNA's) written statement dated 8-6-18 documents, "I was coming out of (another resident's room) from giving a shower. I came around the corner and heard a call light and someone yelling, 'Help.' in (R42's room). I ran in to see R42 laying on the floor in the bathroom seeming to have a very swollen left wrist. I ran to (another floor) to get help." V4's (Licensed Practical Nurse) written statement dated 8-6-18 documents, "(R42) needed to use the restroom. As I came down the hall with the (mechanical lift), I was stopped by a delivery guy. (The delivery guy) said the second floor nurse was busy and needed him to get the nurse on first floor (V4) to trade out the narcotic box. I went to the second floor (a different floor) from where I was working. I went up to second floor. I was off of the unit less than five minutes, when a fall occurred in (R42's room). (R42) has attempted to transfer self to the toilet and fell."	S9999		

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On 10/02/18 at 10:49 AM, R42 was sitting in a wheelchair with a splint on her left wrist and left hand. R42 stated, "(On 8-6-18) I turned on my call light and no one answered it for a long time. When the call light was answered the staff told me they would right back. No one came back, so I tried to get up to go to the bathroom. When I stood up from the toilet I lost my balance. I tried to steady myself with the hand rail, but my hand went between the hand rail and the wall and broke. I had to go to the bathroom real bad and got tired of waiting on someone to help me, so I went myself. There was no one on the floor to help me and I was yelling that I needed to go to the bathroom, but no one came."

On 10/03/18 at 10:44 AM, V5 (CNA/Certified Nursing Assistant) stated, "It was the first night I had worked (R42's) floor since my orientation. I had came out of giving another resident a shower that had took around twenty minutes. I heard someone hollering for help. I found (R42) on the bathroom floor with a broken arm. I was the only CNA on (R42's) floor. I was in the shower room and the nurse was off of the floor, so no one was left on the floor to answer call lights or supervise other residents. (R42) said she had to go to the bathroom really bad and got herself up. (R42) is supposed to be a (mechanical) lift with two staff members for transfers. (R42) uses her call light whenever I work the floor. I had not toileted her before the fall. I was the only CNA and had not toileted (R42) since 6:00 PM that night. I was trying to get showers done. The nurse would have answered call nights when I was in the shower room, but she was on another floor. That left (R42's) floor unsupervised."

On 10/03/18 at 11:31 AM, V4 (Licensed Practical

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Nurse) stated, "I float between floors. (V5/CNA) was working with me. I was bringing a (mechanical) lift in to help (R42) to the bathroom because (R42) had to urinate. I told (R42) that I would be back to help her and a delivery guy stopped me. I then had to go to the second floor. I was off the floor for five or ten minutes. (V5/CNA) was the only staff left on the floor. When I got back, (V5) was yelling that (R42) fell. I could tell (R42's) wrist was broken. I had not offered (R42) the toilet prior to the fall. I started my shift at 6:00 PM. I am not sure how often (R42) is suppose to be toileted."

On 10/03/18 at 12:37 PM, V6 (Registered Nurse) stated that V4 should have toileted R42 before leaving the floor and attending to the delivery guy. V6 also stated that V4 should have asked another staff member to supervise R42's floor while V4 was on another floor and V5 was giving a shower. V6 stated, "Resident care should always come first."

On 10/03/18 at 12:02 PM, V7 (R42's Physician) stated, "The nurse should have toileted (R42) before attending to a delivery man. This would have prevented (R42) from transferring herself and ultimately falling and breaking her wrist. Resident cares should have came first. If the nurse left the floor, and the CNA was giving a shower, then the nurse should have made sure the residents were supervised by somebody."

(B)