Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011688	A. BUILDING: ______ B. WING ______	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASON CITY AREA NURSING HOME	520 NORTH PRICE AVENUE MASON CITY, IL 62664

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S 000	Initial Comments Complaint Investigation 2123455/IL134038	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These regulations were not met as evidence by: Based on observation, interview and record review the facility failed to perform a fall	S9999		

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assessment after falls, ensure fall prevention interventions were in place and failed to provide supervision to prevent falls with injury for one (R1) of three residents reviewed for falls in the sample of three. These failures resulted in R1 obtaining two humerus fractures, a subdural hematoma, and a hip fracture.

Findings include:

The Resident Occurrence Reports for R1, document R1 had nine unwitnessed falls in her room in the last seven months on 10/18/20, 11/23/20, 12/4/20, 12/5/20, 1/15/21, 3/21/21, 5/5/21, and 5/9/21, and had one unwitnessed fall in a common area on 4/20/21.

The State Agency Reports document the following falls with injuries to R1 on the following dates: 10/18/20 obtained a right humeral head fracture; 1/15/21 obtained a right humeral shaft fracture with moderate displacement of fracture fragments; 5/5/21 obtained a subdural hematoma; and 5/9/21 obtained a left femoral intertrochanteric displaced and comminuted fracture.

The facility's Fall Assessment and Management Policy, Revised 4/2019, documents "It is the policy of this facility to assess each resident's fall risk on admission, quarterly, and with each fall. This will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk...The potential for falls will be care planned when appropriate, based on the results of the Fall Risk Assessment. The interdisciplinary care plan will be person centered to reflect the specific needs and risk factors of the resident...Interventions will be based on the fall

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risk assessment and the circumstances surrounding the risk for injury or actual injury or fall...A licensed nurse will consult with the resident's care givers and other interdisciplinary team members in regards to future intervention, and resident specific risk factors."

R1's Medical Records contains the following Fall Risk Assessments and Fall Risk scores for R1: 9/29/20 scored "80" and documents R1 is "High Risk for Falling" and 12/27/20, 3/29/21, and 5/16/21 scored "75" and document R1 "High Risk for Falling." There are no Fall Risk Assessments completed after R1's falls on 10/18/20, 11/23/20, 12/4/20, 12/5/20, 1/15/21, 3/21/21, 4/20/21, 5/5/21, and 5/9/21.

R1's Current Fall Care Plan includes the following interventions: "Make sure my call light is always within my reach...Staff to increase visual checks and to ask resident if she needs to toilet frequently...Staff to provide assistance with ADL's (Activities of Daily Living) d/t (due to) right shoulder fracture...Toilet (R1) before and after every meal."

1. On 5/21/21 at 11:50 am, R1's room is in the middle of the 200 hall; yellow zone hallway. R1's doorway entrance to her room was covered with a semi clear plastic zippered barrier with signage on the wall documenting R1 is in a Droplet Isolation precautions room. There is a bin filled with PPE (Personal Protective Equipment) next to the entrance to R1's room. R1 is sitting up in a low seated reclining wheelchair with lunch tray in front of her. There are no staff in or near R1's room.

On 5/21/21 at 1:30 pm and 5/25/21 at 12:35 pm and 2:00 pm, R1 was lying in bed and there were

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no staff in or near R1's room.

On 5/26/21 at 9:25 am, R1 was sitting up in her low reclining wheelchair with breakfast meal in front of her. There were no staff in R1's room. R1's call light was rolled up her bed blankets on top of R1's bed, out of R1's reach.

On 5/26/21 at 9:27 am, when R1 was asked if she can use her call light, R1 stated, "I can't find it now. I don't know where it is." R1 began looking around her room.

On 5/26/21 at 8:50 am, V6 (Certified Nursing Assistant/CNA) stated R1 can and will use her call light if she needs something. On this same date at 9:32 am, V6 confirmed R1's call light was on R1's bed and was not within R1's reach when R1 was sitting in her wheelchair. V6 stated generally the call light is on R1's chair when she is sitting up.

2. The Resident Occurrence Reports for R1, dated 10/18/20 at 1:20 am, 12/4/21 at 7:20 pm, 1/15/21 at 1:00 pm, and 5/5/21 at 3:00 pm document R1's unwitnessed falls in her room and were related to R1 attempting to get self into or out of her bathroom, with no staff present.

R1's hospital reports document R1 was diagnosed with a right "impacted humeral neck fracture" after her 10/18/20 fall, an "acute fracture of humeral shaft with moderate displacement of fracture fragments" after her 1/15/21 fall, and a subdural hematoma after her 5/5/21 fall. The Resident Occurrence Report for R1, dated 5/9/21, documents another unwitnessed fall in R1's room with unknown activity documented prior to the fall with hospital diagnosis of "left intertrochanteric femur fracture" with surgical

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repair.

The Resident Occurrence Reports for R1, dated 11/23/20, 12/5/20, 3/21/21, and 4/20/21 are also documented as unwitnessed falls and occurred in R1's room with no staff present and without injuries.

On 5/25/21 at 1:30 pm, V2 (Director of Nursing) stated R1 is cognitively impaired and the root cause to (R1's) falls is that she has poor safety awareness related to her dementia. V2 stated staff repeatedly remind R1 to use her call light and ask for assistance prior to getting up but R1 does not always remember. V2 stated it has been more difficult to visualize and get to R1 with her being in a quarantine room and the plastic barrier was harder to see through. V2 stated R1 did fall on 5/9/21 while in the isolation room which was when the facility changed R1's plastic barrier to a semi clear plastic for better visualization. V2 also stated, "We have plenty of staff and have hired more recently...We don't have the staff to assign someone to sit with her or at her door while she is in quarantine...Residents have the right to fall." When asked about frequency of resident checks, V2 stated, "We don't use specific times, staff are to just check more frequently." V2 stated the facility does not do Fall Risk Assessments after every fall, they are done with Admission, Quarterly, and Significant Change Assessments only.

On 5/25/21 at 3:17 pm, V1 (Administrator) stated the plastic barrier to R1's doorway entrance was changed to a semi clear plastic barrier after R1's 5/9/21 fall to enable better visualization of R1.

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