Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		C		
IL6007389		B. WING	B. WING		12/22/2021		
NAME OF 1	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
PIATTC	DUNTY NURSING HO	MONTICE	TATE ST ELLO, IL 61	856			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DRF	(X5) COMPLETE DATE	
S 000	Initial Comments	i)	S 000			- 11	
	Facility Reported Inc	cident of 12/8/21/IL141490	!				
S9999	Final Observations		S9999			92	
6	Statement of Licens	ure Violations:) 				
	300.610a) 300.1210b) 300.1210d)6) 300.3240a)						
	Section 300.610 Res	sident Care Policies					
	procedures, governing the facility which shat Resident Care Policy least the administration the medical advisory representatives of nuther facility. These powith the Act and all ruthese written policies operating the facility least annually by this	y Committee consisting of at or, the advisory physician or committee and ursing and other services in olicies shall be in compliance ules promulgated thereunder.					
	Section 300.1210 Ge Nursing and Persona	neral Requirements for Il Care		DB			
	care and services to a practicable physical, a well-being of the reside each resident's comp plan. Adequate and p	nall provide the necessary attain or maintain the highest mental, and psychological dent, in accordance with rehensive resident care roperly supervised nursing re shall be provided to each		Attachment A Statement of Licensure Violations	3		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PRO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND FOR OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
IL6007389		B. WING			C 12/22/2021		
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\$9999	Continued From pa	ge 1	S9999				
	resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following 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.						
F	Section 300.3240 Al	ouse and Neglect		*			
	a) An owner, license agent of a facility sharesident. (Section 2-	e, administrator, employee or all not abuse or neglect a 107 of the Act)					
	These Regulations v by:	vere not met as evidenced					
	failed to provide safe and R2. R1 had a fa fractured left femur. avoidable falls that re	esulted in injuries requiring R1 and R2 are two residents			×		
	Findings include:				i I		
	and 12/14/21 for R1.	ninistrative Assistant, investigation dated 10/19/21 On this same date, V7 also investigation dated 10/6/21					

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AND PAR OF CONTROL OF THE			A. BUILDING:			
IL6007389		B. WING	<u></u>	C 12/22/2021		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PIATTC	DUNTY NURSING HO	ME 1111 N ST				
	CUMMADVOTA		LLO, IL 61	856 PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
	for R2.					
	document R1's diag Rheumatoid Arthritis Pubis, Sequela, Nor of Sacrum, Sequela Bone Density and S unspecified intracap Femur, Fracture of Clavicle, Difficulty W classified, and Displ Fracture of Left Fen			Ma.		
æ	R1's Minimum Data Set (MDS) dated 10/13/21, documents R1 requires extensive assistance for bed mobility, transfers, toilet use, is not steady and requires staff assist to stabilize. R1's Nursing Admission Screening/History dated 7/1/21, documents R1 has an unsteady gait, poor balance, and a history of falling/recent falls, is confused, and has long and short-term memory problems. R1's Alarms Assessment dated 7/14/21, documents R1 attempts self-transfer and does not use call light. R1's Morse Fall Scale dated 10/13/21, documents R1 is a high fall risk due to an impaired gait and over estimating and/or forgetting limits.					
	12/8/21, documents pressed the call light transfer to commode and prepared items walker in front of R1 from R1 to close the turned away from R2 balance and fell to R3	eport of Resident Incident of R1 was in R1's room, t and requested assist to e. V6 CNA entered R1's room for R1 and placed R1's for transfer. V6 then turned curtain for privacy and as V6 I, R1 stood alone, lost R1's t1's left side, V6 was unable report documents upon				

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PRINTED: 01/21/2022 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: ____ COMPLETED B. WING IL6007389 12/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N STATE ST **PIATT COUNTY NURSING HOME** MONTICELLO, IL 61856 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 inspection R1's left foot was noted to be rotated outward and a leg length discrepancy noted. This report documents R1 had a "surgical nailing" of R1's femur. On 12/8/21, R1 was transferred to one hospital for left hip pain of 10/10 on the pain scale. On 12/9/21, R1 was transferred to another hospital for possible surgery. Awritten witness statement by V6 CNA on 12/8/21 documents R1 called to use the commode - V6 put R1's walker in front of R1 and V6 turned to draw the curtains for R1's privacy and R1 got up and tried to move by R1's self and lost R1's balance and fell. R1's Emergency Department Observation Record dated 12/8/21, per V10 Medical Doctor, documents "patient (R1) presented after fall from her (R1) nursing facility for evaluation of likely hip fracture, left hip fracture was confirmed on imaging". R1's Diagnostic Imaging Report dated 12/8/21, documents acute comminuted fracture involving the intertrochanteric region of the proximal left femur with soft tissue swelling. R1's Operative Report dated 12/9/21, documents the title of the procedure as Cephalomedullary nailing of left proximal femur using a nail system measuring 11.5 (inches) x 20 (inches). On 12/22/21 at 9:47 AM, V2 Director of Nursing (DON) stated on 12/9/21 V6 CNA "should have

prevented a broken hip".

pulled the curtain as soon as she (V6) entered the area, that one little thing could have

The facility's Witnessed Fall Report dated 10/19/21, documents a Certified Nursing

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IL6007389		B. WING		C 12/22/2021		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PIATTO	DUNTY NURSING HO	ME 1111 N ST		250		
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S9999	Continued From pa	ige 4	S9999			
S9999	Assistant (CNA) (Valarm and responde out of bed. V4 asked assistance while V4. The report stated Rattempt to climb out documents V4 returns the light on saw R1 report documents V4 and could not so V4 report documents R1's right elbow me by 4.3 cm and 2.2 creport documents plighting, gait imbala. This report also doc by V4 CNA which stagoing off and when crawled to the bottoway out when V4 to on the lights, when was falling and V4 the documented R1 cut. On 12/22/21 at 9:47 "should have turned the room, you have	4) heard resident's (R1) bed ed to find R1 trying to climb	\$9999			
æ	diagnoses as Histor Parkinsonism, Cogr	ace Sheet, documents R2's ry of Falls, Other Secondary nitive Communication Deficit, generalized, and Other Lack				
	R2's MDS dated 11/8/21, documents R2 requires extensive assistance for bed mobility and transfers, is not steady and requires staff assistance to stabilize, has bilateral lower			ū,		

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _____ COMPLETED С B. WING_ IL6007389 12/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N STATE ST **PIATT COUNTY NURSING HOME** MONTICELLO, IL 61856

(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
\$9999	Continued From page 5	S9999		
	extremity impairments and uses a wheelchair for locomotion.			
	R2's Morse Fall Scale dated 8/9/21, documents R2 has a history of falls, impaired gait, and over estimates/forgets limits.		С.	
	R2's Alarms Assessment dated 6/1/21, documents alarm use for history of falls, climbing out of bed, sliding out of chair/wheelchair, and attempts to self transfer.			
	R2's Care Plan dated revision on 8/10/21, documents R2 is at risk for injury related to declining functional status.		25	
	The facility's Unwitnessed Fall Report dated 10/6/21, documents V8 Licensed Practical Nurse (LPN) responded to R2's alarm and observed R2 lying face down on the floor with right shoulder under body, head against the heater vent, feet under upright wheelchair, and television remote in R2's left hand. The report documents R2 being log-rolled to R2's back and bleeding noted to above R2's right eyebrow measuring approximately 0.5 cm- 1.0 cm with a hematoma to R2's right forehead. This reports documents R2 was transported the the Emergency Department for evaluation and treatment. This same report documents R2 at times does try to transfer self when in room unsupervised. This report documents after dinner V5 CNA assisted R2 to R2's room per R2's request, per V5, R2 did			
	not want to get into bed so V5 made sure R2 had R2's television remote and the call light within reach. This report documents R2 dropped the television remote and bent over to pick it up and fell forward. R2's Emergency Department Report dated			.0

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IL6007389		B. WING		12/22/2021		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PIATTC	OUNTY NURSING HO	ME 1111 N ST MONTICE	AIESI LLO, IL 618	B56		
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S9999	Continued From pa	ge 6	S9999			
	10/6/21, documents: patient (R2) has evidence of contusion with swelling superior and lateral to right orbit, there are multiple superficial linear lacerations present that appear to penetrate into the dermal layer.					
	On 12/21/21 at 2:38 PM, V3 CNA stated R2 told V5 CNA that R2 wanted to go to his room. V3 stated the CNA V5 is an agency CNA. V3 stated V3 was on break, V5 remained on the unit, and when V3 was coming back V3 heard R2's call light so V3 went to R2's room but R2 was already on the floor. V3 stated R2 had cut around R2's eye and no one was in the room with R2. V3 stated when V3 asked V5 what happened V5 stated V5 didn't know R2 was a fall risk or that R2 couldn't be left alone in R2's room. V3 stated V3 gave V5 the "cheat sheet" listing information for each resident that documented "don't leave alone in room" referring to R2. V3 stated V3 left V5 alone on the floor other than the nurse and did not call for the float CNA to come to the floor. On 12/22/21 at 11:19 AM, V8 Licensed Practical Nurse (LPN) stated around the time of the incident with R2, V8 is typically doing treatments					
	doing. V8 stated V3 on break and V8 wa: CNA on the floor but time working. V8 stated V5 was aware of fall V8 stated R2 is to be fall monitoring while fall safety precaution. On 12/21/21 at 3:03 should have went on should have called the control of the control o	to know what people are did tell V8 that V3 was going is aware there was an agency didn't know if it was V5's first ated V8 assumed the CNA, safety precautions for R2. It close to the nurse's desk for R2 is in R2's wheelchair for R2. PM, V2 DON stated V5 break with V3 and V3 are float CNA to come assist at on a break instead of		91		

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