STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011746	A. BUILDING: _____ B. WING _____	C 08/17/2022

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S 000	Initial Comments Investigation Facility Reported Incident: of 07.06.22\IL149442	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care 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. These regulations were not met as evidenced by: Based on interviews and records reviewed the facility failed to safely assist a resident while providing incontinence care to prevent an avoidable accident for 1 of 3 (R1) residents reviewed for safe care, the facility also failed to ensure fall prevention interventions were in place to include bed bolsters and floor mats to reduce the risk of fall with injury for 1 of 3 (R5) resident reviewed for fall prevention interventions. These failures resulted in R1 falling to the floor while being assisted by staff sustaining a laceration to the head requiring 2 sutures, and R5 falling from the bed to the floor and sustaining an acute right superior and inferior pubic ramus fractures. Findings include Review of incident report dated 7/6/2022 and documents R1 with diagnosis that include Unsteadiness on feet, syncope and collapse, Weakness, Unspecified dementia, unspecified atrial fibrillation, and hypotension. Description of Occurrence: R1 was adjusting incontinence brief, lost balance and fell. Aide present when R1 was	S9999		

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S9999	Continued From page 2 pulling up briefs-lost balance but aide could not stop the fall. V5's nursing note dated 7/6/2022 at 3:50 AM documents the following: While staff member assist resident with pulling up her incontinence brief, resident lost her balance falling to her right side on to the floor. Resident has hit her head causing laceration to site. Controlled bleeding currently. Writer and staff member assist resident to bed. Site cleansed with normal saline and gauze then steri-strips applied. On 8/12/2022 at 10:18AM V5 (LPN) states, what her note says is most accurate to what happened that day. 8/12/2022 at 9:39 PM V6 (CNA) I was trying to help her pull up a incontinence brief. R1 was sitting on the bed. close to edge. I was putting on incontinence brieg. V6 states He was in front of R1 trying to pull up her incontinence brief and she tilted over and hit her head on the side of the bed. She fell to the right side. V6 states, R1 was always dizzy so made sure she set on the bed. V6 states, "When she stands the balance isn't always there." Never see her flop over like that before. V6 states, he thought maybe she was kind of sleepy. V6 states, that when looking back he could have made sure R1 was always fully in the bed and lying down when changing her. The objective when helping with incontinence is to make sure they don't fall. V6 states, "looking back I could have left her in bed, that is the way I'm doing it now." On 8/11/2022 at 2:18 PM V3 (Restorative Nurse) states she does investigations for fall. Surveyor asked what V3 thought the cause of R1's fall was after her investigation. V3 states, " It could be improper aid or weakness. V3 states she expects	S9999		

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staff to "keep them [residents] safe and not drop them." I don't understand how she fell because she doesn't have increased weakness." V3 states, she thought it more educational issue with staff. V3 states V6 told her R1 just fell, and he didn't have time to catch her.

On 8/16/2022 at 5:20 pm V11 (ADON) states when helping someone with incontinence care, first check care plan and supplies ready, skin check, safety check, wheelchair locked. transfer mode known, make sure every in place to prevent falls, not leaving person unattended. you must be attentive most importantly you want to prevent falls.

Reviewed facility's in-service with V6 (CNA) with date of 7/6/2022 and documents a 10-minute in-service with topic of Supporting Resident's during incontinent care.

Review of R1's fall care plan dated 2/17/2022 documents: resident at risk for falling related to diagnosis of history of altered mental status, Atrial Fibrillation, Dementia, DM < Syncope.

Review of R1's ADL care plan dated 6/23/2022 documents: R1 is limited in ability to transfer self-related-to decreased strength and balance and requires a restorative transfer program. Care plan also documents the following: R1 is limited in ability to move independently in bed related to decreased mobility and weakness and requires restorative a bed mobility program.

Review of Hospital records document the following on page 15: History: Laceration. Patient sent to ED for evaluation after fall with head injury. Patient had a witnessed fall from wheelchair and sustained scalp laceration. Fall:

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S9999	Continued From page 4 The accident occurred 1 to 2 hours ago. Fall occurred: from wheelchair. She fell from a height of 1 to 2 ft. She landed on a hard floor. Review other hospital records dated 7/6/2022 page 21 documents: laceration repair with 2 sutures. Review of Falls and Fall Risk, managing policy documents: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. R5's MDS dated 8/3/2022 section G documents R5's bed mobility requires extensive two+ person's physical assist. R5's MDS section C documents R5's Brief Interview for Mental Status (BIMS) of 6/15. Review of R5's 5/29/2022 fall report documents the fall report. 1) Root cause determination documents resident: rolled out of bed. 2) Based on the above assessment and direct observation at the location of the fall, the fall management team (FMT) determines the following new interventions and recommendations need to be implemented: Bolsters, UA and CS. R5's fall care plan start date 9/27/2016 and documents: bilateral Bolsters at rest. Approach start 5/29/2022. On 8/11/2022 at 3:34 PM V9 (CNA) states she found R5 on the floor on the 7/21/2022 fall and R5 said she didn't know how she got on the floor	S9999		

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and V9 states she then told the nurse. V9 states R5 is bedridden. V9 states, R5 had bolsters on and they weren't tightened properly. V9 states when she checked the straps, they were loose. V9 states, "I told the nurse it was loose. It wasn't done the proper way and it was loose." Surveyor asked her to clarify what she meant by loose. V9 states, the bolster was sitting there loose without being attached to the bed. V9 states after the fall the staff got in-serviced on how to properly apply the Bolsters. Surveyor asked V9 if she checked the bolsters to see if attached correctly and she said, "No" She assumed it was done correctly. V9 states she didn't know until the resident fell that it wasn't attached. V9 states, "Now we check all the time because we don't want anyone falling."

On 8/6/2022 at 10:40 AM V10 (LPN) states a CNA called her to the room and R5 was on the floor on floor. V10 states, she asked R5 what happened and if she was okay or in pain. V10 states R5 said her back hurt. V10 states she and three CNA's put R5 back in the bed. V10 states, at the beginning of the shift, they must make sure the bolsters are tight. V10 states, "When it is tight it would be difficult for her to role." V10 states they knew before the last in-service to check the bolsters and then got the in-service about it.

V10 nurse's progress note dated 7/21/2022 at 8:45 PM documents: Writer called to the room by CNA to come to resident's room. On getting there, resident was observed on the floor on her back. Resident was asked if she was okay and what happened. Resident told writer" My Back is hurting me" but could not tell writer what happened or how she got on the floor. Writer obtained vital signs. See Matrix. Writer and

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other staff assisted resident back to bed. Resident was able to move extremities per usual. No bruising or open area observed. Nurse Practitioner made aware of fall and order received for a stat x-ray to back hip and pelvic are. Order received and carried out. Resident POA called and made aware. All questions and concerns addressed. Resident assisted with needs and made comfortable in bed with bin in lowest position and head of bed elevated and call light in reach.

Review of R5's fall report Event Audit documents the following:
1) Root cause determination documents resident: rolled out of bed unable to determine how per resident.
2) Based on the above assessment and direct observation at the location of the fall, the fall management team (FMT) determines the following new interventions and recommendations need to be implemented: 1) Bolsters replaced, 2) staff education on bolsters. 3) In-service dated 7/22/22 documents V9 and V10 getting in-serviced on the following: Dimensions of bolsters-comfort/condition/function/placement.

On 8/16/2022 at 5:20 pm V11 (ADON) states the restorative aids educate how to put on the bolsters. "They are a little tricky." V11 states Resident has to be taken out of the bed to adjust the bolsters." V11 states, that "bolsters are there so resident doesn't roll out of bed." V11 states, every staff member going in the R1's room should be checking that the bed low, oxygen on, bolsters are secure and call light within reach.

R5's radiology report dated 7/27/2022 documents the conclusion of bilateral hips X-ray as follows:

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S9999	Continued From page 7 Acute right superior and inferior pubic ramus fractures. The facility's fall risk, managing Policy: 6. Staff will identify and implement relevant interventions to try to minimize serious consequences of falling. (A)	S9999		