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
	IL6002950	A. BUILDING: ______ B. WING ______	C 09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR HAVENS SENIOR LIVING	1790 SOUTH FAIRVIEW AVENUE DECATUR, IL 62521

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S 000	Initial Comments Facility Reported Incident of August 17, 2022 IL150835	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
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 interview and record review, the facility failed to prevent falls with injuries for three residents (R4, R6, R7) of four residents reviewed for falls in the sample of four. This failure resulted in R7 rolling out of bed and sustaining a right frontal scalp laceration, requiring sutures.

Findings include:

1. R7's undated Medical Diagnoses document R7's diagnoses as: History of Falling, Mild Cognitive Impairment, and Muscle Weakness.

R7's Minimum Data Set (MDS), dated 6/11/22, documents R7 as not cognitively intact, requires extensive assistance of two person physical assist for bed mobility and extensive assistance for personal hygiene.

R7's Fall Risk Evaluation, dated 8/19/22, documents R7 as a high fall risk.

R7's Care Plan, dated 8/22/22, documents R7 is at risk for falls related to deconditioning, poor

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S9999	Continued From page 2 communication/comprehension, and unaware of safety needs. R7's Emergency Care Center After Visits Summary, dated 8/26/22, documents R7 sustained a right frontal scalp laceration requiring sutures. The facility's Fall Report, dated 9/1/22, documents V7, Certified Nursing Assistant/CNA was washing R7, and turned around to grab a towel and R7 rolled off the bed, sustaining a forehead laceration. On 9/7/22 at 10:17 AM, V2, ADON (Assistant Director of Nursing) stated R7 fell because V7 turned away from R7. 2. R4's undated Diagnoses page documents R4's diagnoses as: Difficulty Walking, Muscle Weakness, Age-related Osteoporosis without current pathological fracture, Other Abnormalities of Gait and Mobility. R4's Minimum Data Set (MDS), dated 7/20/22, documents R4 as cognitively intact, requires extensive assistance of one physical assist for transfers and toileting, and is not steady and can only stabilize self with staff assistance. R4's Care Plan dated, 7/31/22, documents R4 ambulates using a two wheeled walker and gait belt, provide walker and gait belt (for R4). The facility's Fall Report, dated 8/17/22, documents V8, Certified Nursing Assistant (CNA), was pushing R4 out of the bathroom, and R4 fell forward onto the floor onto R4's face.	S9999		

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R4's Hospital Records. dated 8/18/22, document for the cervical spine, a small density adjacent to the anterior inferior aspect of C6 (cervical vertebra), mild prevertebral soft tissue prominence, bony irregularity at the anteroinferior endplate of the C6 vertebra, findings concerning for acute avulsion fracture. These same records document a small laceration to upper underside of upper lip, nasal deformity, signs of injury and nasal tenderness present; angulation bilateral nasal bone consistent with age indeterminate fracture, new since 2013, correlate with symptoms and point tenderness.

On 9/7/22 10:27 AM, V8, CNA, stated V8 first took R4 to the bathroom, helped R4 to the toilet, left R4 in the bathroom by R4's self, and had R4 turn the call light on when done. V8 stated when V8 came back, V8 transferred R4 from the toilet to the wheelchair with a gait belt and one assist, and as V8 was pushing R4 from the bathroom in the wheelchair, R4 just fell over to the floor on R4's face. V8 stated V8 is not sure if R4 has a history of falls, if there are care plans at the nurses station that all staff have access to, but V8 has not looked at R4's care plan.

On 9/8/22 at 10:10 AM, R4 stated a gait belt was not used to assist R4 when R4 fell on 8/17/22, and they never use a gait belt with R4.

On 9/8/22 at 12:40 PM, V1, Administrator, stated V1 believes the resident (R4) when R4 said R4 did not have a gait belt on R4 for the fall on 8/17/22.

3. R6's undated Medical Diagnoses document R6's diagnoses as: Morbid (severe) Obesity due to excess calories, Hemiplegia and Hemiparesis affecting left non-dominant side, Muscle Wasting

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and Atrophy, Primary Generalized Osteoarthritis, Age-Related Osteoporosis with current Pathological Fracture, Muscle Weakness, Other Secondary Scoliosis, Charcot's Joint.

The facility's Fall Report, dated 7/30/22, documents R6's left foot was not on the floor board of the mechanical lift, and the lift strap was not placed correctly on R6 during a transfer. The facility's Employee Disciplinary Report, dated 7/30/22, documents nature of incident as disregard for resident safety and failure to follow instruct/procedures, with V5, Certified Nursing Assistant (CNA), as the recipient of the discipline. Employee comments on this same report document V5 as stating, "I'm sorry, tell them it was my fault".

R6's MDS, dated 7/25/22, documents R6 is cognitively intact.

R6's Fall Risk Evaluation, dated 7/30/22, documents R6 as a fall risk.

R6's Care Plan, dated 7/31/22, documents R6 is at risk for falls due to decreased physical mobility and weakness.

R6's Treatment Administration Record (TAR), dated 8/1/22 through 8/31/22, documents R6 receiving treatments to R6's left lower extremity 7/31/22 through 8/24/22.

On 9/7/22 at 10:50 AM, V2, Assistant Director of Nursing (ADON), stated the CNA, V5, transferred R6 improperly for the sit to stand lift. R6 was not put on the sit to stand correctly, causing R6 to be brought to the ground receiving an abrasion to his lower left extremity. V2 stated V5 received a disciplinary write up, but then V5 just quit. V5 was

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unable to be reached as V5's phone was disconnected.

On 9/8/22 at 3:00 PM, R6 stated, "I was not on the lift very good and was slipping out. I don't know what was wrong, there has not been any problems doing this before". R6 also stated R6 got a cut on R6's lower leg.

The facility's Falls and Fall Risk Management policy, Revised August 2008, documents the staff will identify interventions to the resident's specific risks and causes and to try to prevent the resident from falling.

The facility's undated Mechanical Lift Transfers policy documents the procedure is to follow the manufacturer's instructions for the specific type of mechanical lift and to use two staff members when transferring a resident on sling mechanical lift.

(B)