STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008999	A. BUILDING: _____ B. WING _____	C 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LACON REHAB AND NURSING	401 9TH STREET LACON, IL 61540

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S 000	Initial Comments Investigation of Facility Reported Incident of 05-05-2022/IL147022	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 are not met as evidenced by: Based on interview, and record review, the facility failed to safely assist a resident during re-direction for one resident (R1) of three residents reviewed for falls in a sample of three. This failure resulted in R1 sustaining pain and a fractured femur. Findings include: The facility's Fall Reduction policy, revised 11-5-19, documents "To provide an environment that remains as free of accidents hazards as possible. To identify residents who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent or minimize fall related injuries."	S9999		

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S9999	Continued From page 2 R1's clinical record documents R1 has diagnoses including Vascular Dementia with Behavioral Disturbance, General Anxiety Disorder, and Unspecified Dementia without Behavioral Disturbance. R1's Fall Risk Assessment, dated 3-19-22, documents R1 as a medium risk for falling. R1's Minimum Data Set/MDS assessment, dated 1-14-22, documents R1 as severely cognitively impaired. This assessment also documents R1's functional status for "locomotion off unit" as requiring supervision (oversight, encouragement or cueing) for self-performance and one person for physical assist. Locomotion off unit is described as "how a resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from only one floor, how resident moves to and from distant areas on the floor. If in a wheelchair, self-sufficiency once in chair." The facility's incident investigation report for R1, dated 5-5-22, documents "On 5-5-22, at 4:15pm (R1) had a witnessed fall from wheelchair, resident was observed to be sitting on edge of wheelchair, CNA (Certified Nurse Assistant) (V4) attempted to assist (R1). (R1) fell from wheelchair onto (R1's) bottom, hitting (R1's) head on the wall." R1's Nursing Progress Note, dated 5-5-22 at 7:29pm, documents "Moaning crying and holding right hip. Face grimacing present." R1 received pain medication and an X-ray of the right hip. R1's X-ray report, dated 5-5-22, documents	S9999		

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S9999	Continued From page 3 "Findings: An intertrochanteric fracture is identified on the right. Superior medial displacement of the distal fracture fragment is noted." On 5-20-22, at 11:12am, V3 Registered Nurse/RN/MDS Coordinator stated the following: "I was in the conference room and heard yelling that someone was on the floor. (R1) was in the entry way past the dining room. I heard a CNA (V4) yell out that someone fell. (V4) told me that (V4) was trying to keep (R1) on the unit. When (V4) turned (R1's) wheelchair around (R1) fell out onto (R1's) bottom...(R1) kind of leans forward in (R1's) wheelchair and scoots with (R1's) feet... (Afterwards) we educated the staff on making sure a resident's positioning is correct in the wheelchair before moving them." R1's Incident note, dated 5-5-22 at 5:30pm, titled "Technical Error" and signed by V3 RN documents a struck-out note stating the following: "(R1) was wheeling towards going off the unit before dinner. CNA went to redirect (R1) and started to turn (R1's) wheelchair around. (R1) was sitting towards the front of the wheelchair and fell onto her bottom and fell back and hit her head on the wall...CNA was educated to notice patient positioning in wheelchair before moving/turning them around CNA acknowledged understanding..." On 5-23-22, at 8:03am, V3 RN stated that the struck-out incident note from 5-5-22 was struck out by the electronic system due to V3 deleting the first incident note and creating a second incident with major injury note. At this time, V3 confirmed that the information in the struck-out incident note is correct in how (R1's) fall happened. V3 stated "the CNA stated she had	S9999		

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S9999	Continued From page 4 turned (R1) around. (R1) leans forward in the wheelchair so her butt is not completely all the way back. That is normal for (R1) when she's scooting along." On 5-20-22, at 1:01pm, V4 CNA stated the following: "I came back from the kitchen and noticed (R1) by the double doors leading out of the unit. I went to flip (R1) around to take (R1) to the bathroom. I had another resident with me who was standing next to me. I noticed (R1) was sitting like she normally does - halfway in the wheelchair with her bottom not to the back of the wheelchair and (R1) was leaning a little forward. I'm not sure if I maybe turned her a little too fast. She had slid out from the chair from me moving her. She landed on her bottom and hit her head on the wall...I should have pushed her back more into the wheelchair and gone a little slower. We were educated the next day on those things in order to prevent it from happening again." The facility's Employee Performance Improvement form, dated 5-6-22, documents for employee V4 CNA: "Ensure resident safety with transfers...Employee Comments: "I was bringing (R1) back down to take (R1) to the bathroom before dinner. I am regretful for this experience and will make sure the residents are in proper position to move and minimize my distractions." On 5-20-22, at 2:32pm, V2 Director of Nursing/DON stated that (V4 CNA) was trying to guide (R1) and turned (R1's) wheelchair to bring (R1) back to the unit. (R1) had poor posture in the wheelchair. I told (V4) to make sure next time to check (R1's) position in the wheelchair for safety concerns."	S9999		

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S9999	Continued From page 5	S9999		

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