STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003321	A. BUILDING: _____ B. WING _____	07/08/2022

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FREEBURG CARE CENTER	746 URBANNA DRIVE FREEBURG, IL 62243

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b)5) 300.1210 c) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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 requirements are not met as evidenced by: Based on observation, record review and interview, the facility failed to implement progressive interventions and provide supervision to prevent falls for 3 of 7 residents (R34, R55, R138) reviewed for accidents/supervision in the sample of 39. This failure resulted in R138 falling, hitting his head, and being sent to the Emergency Room (ER). R138 sustained multiple intracranial hemorrhages including intraparenchymal hemorrhage in the left temporal region with subarachnoid blood that caused death. Findings include:	S9999		

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S9999	Continued From page 2 1. On 4/17/2020, R138 was admitted to the facility with the following diagnoses: hypothyroidism, COVID-19, hypertension, dementia without behavioral disturbance and major depressive disorder. R138's Morse Fall Scale, dated 7/20/2021 documents he was high risk for falls. R138's Minimum Data Set (MDS), dated 7/24/2021, documented R138 had severely cognitive impairment. R138's MDS documented his balance was not steady, only able to stabilize with staff assistance when walking, moving from seated to standing position and turning around. The MDS documented R138 required limited assistance of one person for transfers and ambulation. The MDS documented R138 utilized a walker and had no falls. R138's Late Entry Incident Note, dated 8/8/2021 at 9:23 AM documents "res (resident) was agitated this morning before breakfast. Res pacing with walker up and down C Hall. Res redirected several times and unwilling to sit down or go back to bedroom. Res was standing against the wall at the top of C Hall. This nurse heard a loud noise and noted that res was laying on the left side on the floor where res had been standing. Assessed res and no injuries noted. Vitals stable at 110/58; P60; R 16; T 96.7; O2 100%. Res denies pain and denies hitting head, but this nurse started neuro checks because fall was not witnessed and unsure if resident actually hit head. Called and left message for POA (Power of Attorney) to call facility. Res resting in bed at this time." R138's Care Plan, dated 9/1/2021 documents he was at risk for falls/contractures R/T (related to)	S9999		

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S9999	Continued From page 3 decreased mobility, weakness, hypothyroidism. The Care Plan documented that "On 1/21/21, Certified Nurse's Aide (CNA) noted res (resident) up in BR (Bathroom) prior to going to next room. When CNA walked out into hall, res laying on back in BR." The Care Plan documented that on 8/8/21, R138 was agitated this am pacing C hall-redirection unsuccessful-had a fall in hallway. The Care Plan Goal documented "(R138) placed in fall management, free of signs/symptoms pain." The Care Plan Intervention, dated 8/8/21 documented "1 on 1 spent with resident." R138's Care Plan Interventions, dated 9/1/21, documented "Maintain safe environment to room/facility to prevent injuries, well-lit environment. Observe res (resident) for any unassisted transfers/ambulation status. Remind to wait assist and assist res PRN. B & B (Bowel and bladder) before meals/after and PRN (as needed). Instruct/remind resident to use of call lights when assist needed. Report any unsteady balance/gait to Nurse/ Phys (physician) PRN. Report any decline in safety awareness to Nurse PRN. Change of position every two hours and PRN. Non skid pad in chair as needed. Bed to low position and locked. Monitor use of eyeglasses, hearing aids. Reinforce assistive devices. Evaluate need for an adjustment in Resident's daily activity schedule. Observe res for restlessness. Assist resident to bathroom." This Care Plan did not address R138's need for increased supervision when ambulating. R138's Health Status Note, dated 9/27/21 at 10:16 AM documents "Resident was taken to restroom had a large BM (bowel movement) because weak, and staring off. This nurse assessed resident elevated HOB (head of bed) and elevated feet. Resident able to grasp with	S9999		

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S9999	Continued From page 4 upper extremities without difficulty. Able to smile without difficulty. Pushed PO (by mouth) fluids, answered questions without difficulty. Stated he felt better. V/S (vital signs) 100/60 (blood pressure), 97.3 (temperature), 88 (pulse), 20(respirations), SPO2 (oxygen saturation levels) 98% RA (room air). Placed on Mxxxxxxxxxx (secure clinical communication tool). Will monitor." R138's Incident Note dated, 9/27/2021 at 11:04 PM documents "Resident leaning against dining room wall. Resident had a fainting episode and fell onto the floor at 5:30 PM. Resident drooling, not responsive at first. Resident became more and more responsive after about 10 minutes. Vitals 97.1,68,20,118/88,98%. POA notified and agreed resident should be sent to ER (emergency room) for evaluation and treat. Doctor also notified. Resident left by ambulance without any resistance at 6:28 p.m. Nurse called at 10:00 PM to check on the status of resident and was informed resident is being admitted with GI bleed." R138's Fall Information Form, dated 9/27/2021 written by V14, Licensed Practical Nurse (LPN) documented at 5:30 PM "Resident was standing in dining room against the wall. Resident then fainted and fell to the floor. Resident sent to ER for evaluation." The form documented that the incident was not witnessed. The form documented R138's family was notified at 5:45 PM and his physician was notified at 6:00 PM. R138's Electronic Medical Record, dated 9/27/2022 documents no further assessment of the R38 after he fell at 5:30 PM. There were no documented neurological checks after this incident occurred.	S9999		

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S9999	Continued From page 5 R138's Communication - with Family/NOK (Next of Kin/POA (Power of Attorney) Note dated 9/28/2022 at 3:52 PM documents "Call received from POA. She states resident has been placed on hospice care for brain bleed that the hospital medical team has been unable to control. She states family wishes to have any photos or cards of resident's but donates all clothing at this time." The Facility's Final Report of Serious Incident dated 10/1/2021 documents "(R138) is a 95 year old resident with a diagnosis of hypothyroidism, history of COVID-19, essential hypertension, unspecified dementia without behavioral disturbance and major depressive disorder. (R138) is alert and oriented x 2, able to make all needs known, his primary mode of transportation is wheeled walker which he can ambulate without assistance. At approximately 5:30 PM on 9/27/2021 (R138) was ambulating in the dining room when he stopped and rested against the wall. (V15. Licensed Practical Nurse/LPN) noted his appearance changed with him staring straight ahead and appeared to faint and fell to the floor landing on his right side before any staff could get to him. (V15) and (V14, LPN) responded immediately and performed assessment, neurological assessment was abnormal due to loss of consciousness, vital signs were normal for (R138.) Upper and lower extremities showed no signs of injury. Nurse noted hematoma to right forehead starting to form. (R138) became alert and more responsive after approximately 10 minutes. (V15) stayed with (R138) while (V14) contacted the medical director, his physician and received orders to transfer to hospital of choice for further evaluation and treatment. Medical director, Illinois Department of Public Health (IDPH), Administrator, DON and POA notified in	S9999		

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S9999	Continued From page 6 timely manner. Conclusion: no abuse was suspected. (R138) was sent to a local hospital for further evaluation and treatment. Immediate intervention was staff stayed with (R138) until ambulance arrived. (R138) was admitted with a diagnosis of intracranial bleed with midline shift. CT (Computerized tomography) scan showed multiple intracranial hemorrhages. He was admitted to general in patient and POA wanted comfort measures only. (R138) passed away the next day at the hospital." R138's Hospital Paperwork, dated 9/27/22, documents diagnosis of fall with head trauma and multiple intracranial hemorrhages including intraparenchymal hemorrhage in left temporal region with subarachnoid blood. The Hospital Report documents "The resident is a 95 year old male with past medical history significant for hypertension (high blood pressure) hypothyroidism, dementia, depression, mitral valve insufficiency and COVID-19 infection December 2020. Patient presented to our ED (emergency department) via EMS (emergency medical services) from the nursing home secondary to a fall, patient was witnessed falling from a chair and struck his head on the tile floor, no loss of consciousness, patient unable to provide history information obtained from records, in the ED patient was evaluated CT (cat scan) showed multiple intracranial hemorrhages including intraparenchymal hemorrhage in the left temporal region with subarachnoid blood and parenchymal contusions, neurosurgery were consulted. There was a 3 to 4 centimeter hematoma to left parietal scalp. Patient was given IV (intravenous) Keppra, IV tranexamic acid, intensivist was consulted, and patient get admitted for further evaluation and treatment. Patient was admitted to ICU (intensive care unit.)	S9999		

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S9999	Continued From page 7 Discharge condition: poor, discharged to inpatient Hospice. Hospice note: patient was recently admitted after a fall and was diagnosed with intracranial bleed with midline shift and is requiring total care of activities of daily living (ADLs.) The patient is lethargic, requiring IV gtt (drop) Morphine (narcotic pain medication) at 2 milligrams (mg)/hr (hour.)" On 7/6/2022 at 12:21 PM V28, LPN stated she was the restorative nurse and remembered R138. V28 stated "He walked with a walker and was supposed to only walk with staff assistance because he had unsteady gait, but he would often walk by himself. He was a high fall risk and staff had to remind him often not to walk alone." On 7/7/2022 at 11:00 AM V13, Certified Nurse's Aide, CNA stated he works day shift and recalled R138. V13 stated R138 was a walk to dine resident. V13 stated R138 walked unsteady on his feet so staff were supposed to walk with him. On 7/7/2022 at 11:14 AM V12, LPN stated she remembered R138 and stated he walked with a walker but only with staff assistance because he was unsteady on his feet. On 7/7/2022 at 11:20 AM V14, LPN remembered R138. She stated R138 walked with a walker with staff assistance. V14 stated she didn't see R138 fall on 9/27/21, staff alerted her he fell in the dining room and her and another nurse (name unknown) assessed R138. V14 stated she didn't recall if he hit his head or not, he didn't have any injuries from the fall that she could see. V14 stated after R138 fell he initially wasn't responsive but then he opened his eyes. V14 stated she called the family and physician and got an order to send him to the hospital for further	S9999		

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S9999	Continued From page 8 evaluation and treatment. R138 stated she called the ambulance company directly, she did not call 911 because it wasn't a medical emergency. On 7/7/2022 at 11:28 AM V15, LPN stated she works evening shift and was familiar with the resident. He was confused and ambulated with a walker with staff assistance. He was unsteady on his feet to ambulate alone. She assessed him when he fell in the dining room on 9/27/21 but wasn't assigned to her. She didn't recall a head injury. V15 stated after R138 fell he was more confused than usual and was no longer communicating verbally. She felt this was a medical emergency after he fell because he had an altered mental status. On 7/7/2022 at 2:30 PM the Director of Nurses (DON) stated when a resident falls staff are expected to document everything from what they saw and what the assessment was and to be as descriptive as possible in the nurses note. She spoke to staff after the fall and V15, LPN reported the resident had a hematoma forming on the side of his head and V14, LPN reported the resident was unresponsive for a bit after the fall which means he lost consciousness and that is considered a medical emergency and 911 should have been called. She expected staff to call the resident's family and physician immediately after a fall. She also expected staff to get neuro checks when a resident has a head injury and to apply ice to the area. On 7/7/2022 at 2:00 PM V19, R138's Physician, stated he didn't recall the specifics of R138 falling in September 2021. V19 stated he has no notes on the fall the nurse must have called after the doctor's office closed for the day because if it was during office hours, he would have notes about	S9999		

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S9999	Continued From page 9 the fall. V19 stated when a resident falls and loses consciousness it is considered a medical emergency and 911 should be called. He also expected staff to document what occurred with the fall in the resident's medical record especially document when a resident has a head injury. If the resident fell and hit his head that could cause a brain bleed and could have been a factor in his death. The facility's undated Neurological Assessment - Head Treatment policy documents the neurological assessment form is initiated by the nurse immediately upon noting any trauma to a resident's head. The assessment lists various items that are used to indicate presence of intracranial pressure. It is important to note the resident's "normal" neurological signs to accurately judge changes that are noted during the use of this assessment. A weak hand clasp is not a significant if it was noted to be present before initiation of the forms for example. A 72-hour assessment is done in full according to this time scheduled: every 15 minutes x 4, every half hour x 2, every four hours x 4, then every 8 hours for the last 48 hours. Levels of consciousness nurses noted by checking whether resident is oriented, disoriented, restless or drowsy. Any change in the level of consciousness is one of the earliest and most sensitive indicators or increased intracranial pressure. Summary: altercations in consciousness provide the best guide for the nurse to estimate intracranial pressure. (A)	S9999		