Illinois Department of Public Health

PRINTED: 12/21/2022
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012512	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON COUNTRYSIDE MANOR	606 EAST IL HWY 15 MOUNT VERNON, IL 62864

(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
S 000	Initial Comments Facility Report Incident of 10/13/22/IL152904	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 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. 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 interview, observation and record review, the facility failed to ensure a resident's	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 bed was maintained in a stabilized, locked position for 1 (R3) of 7 residents reviewed for falls. This failure resulted in R3 leaning against the bed, falling, and sustaining a right femoral fracture. This past non-compliance occurred between 10/13/22 and 10/20/22. The Findings Include: R3's Face Sheet documents he was admitted to this facility on 09/27/22 with admission diagnoses to include - Displaced fracture of base of neck of right femur, subsequent encounter for closed fracture with routine healing, pulmonary embolism without acute cor pulmonale, systolic (congestive) heart failure, essential (primary) hypertension, chronic atrial fibrillation, benign prostatic hyperplasia with lower urinary tract symptoms, presence of urogenital implants, Parkinson's disease, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, constipation, unsteadiness on feet, cognitive communication deficit, repeated falls, weakness, abnormalities of gait and mobility, need for assistance with personal care, history of falling, other symptoms and signs involving cognitive functions and awareness, muscle wasting and atrophy. Additional diagnoses include - Covid-19 - 10/09/22, viral pneumonia- 10/13/22, acute respiratory failure with hypoxia - 10/13/22, hypo-osmolality and hyponatremia - 10/13/22, urinary tract infection - 10/13/22, proteus (mirabilis) (morganii) as the cause of diseases - 10/13/22; fracture of unspecified pubis, subsequent encounter for fracture with routine healing - 10/14/22. R3's admission MDS (Minimum Data Set) dated	S9999		

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S9999	Continued From page 2 10/05/22, section C (cognitive patterns) documents a BIMS (Brief Interview for Mental Status) of 9, indicating R3 was moderately cognitively impaired. Section G (Functional Status) documents R3 required extensive two+ person assist for transfers. R3's admission Fall Risk Assessment dated 09/27/22 documents a score of 22, indicating R3 is at high risk for falls. R3's post Fall Risk Assessment dated 10/17/22 documents a score of 19, indicating R3 remains at high risk for falls. R3's Initial Care Plan dated 09/29/22, updated on 10/13/22 includes - "Problem: Problem Start Date: 09/29/2022. Category: Falls - I am at risk for falls due to cognitive impairments, poor safety awareness, unsteadiness on feet, muscle atrophy, repeated falls prior to facility admission, abnormalities of gait and mobility. I have a foley catheter. I may experience symptoms of Parkinson's Disease. I am s/p ORIF (status post open reduction internal fixation) due to right femoral neck fracture. I require verbal cues/reminders and staff assistance with mealtimes, ADL's (activities of daily living) and mobility. I attempted to self-transfer unassisted out of my wheelchair. The bed rolled due to bed not locked. I was sent to ER (emergency room) for eval and treat. On 10-13-22, all beds in facility were checked for locked position and there was a staff in-service to ensure beds are locked after care provided ...Goal: Long Term Goal Target Date: 12/29/2022. Resident will remain free from injury ...Approach: Approach Start Date: 09/29/22: Give resident verbal reminders not to ambulate/transfer without assistance. Keep call light in reach at all times. Keep personal items and frequently used items within reach. Observe frequently and place in supervised area when out	S9999		

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S9999	Continued From page 3 of bed. Place resident in a fall prevention program. Provide toileting assistance." R3's hospital discharge summary dated 09/27/22 includes - Discharge Instruction Sheets Provided: ... Hip Fracture Treated with ORIF, Care After ... Patient Instructions: Discharge to (skilled nursing facility), weight bearing as tolerated ... PT/OT (physical therapy/occupational therapy) eval and treat ... R3's progress note dated 09/29/22 at 5:31 PM, documents in part that R3 sustained a fall at home resulting in a right femoral neck fracture with subsequent repair, and admission to this facility for rehab and care on 09/27/22. On 11/01/22 at 12:37 PM, V4 and V7 (Certified Nursing Assistants/CNA's) were working the hall where R3 previously resided. V7 stated she works PRN (as needed) and did not work with R3 on 10/13/22, but knew he had a fall that day. V4 relayed that R3 had just returned to the facility on the afternoon of 10/13/22 from a hospitalization due to other issues including Covid-19, and a bed had been moved to the room he would be in while quarantined. V4 stated she was clocking in for her shift on 10/13/22 when she was informed R3 had fallen in his room. V4 stated R3 reported to staff he had gotten up from his wheelchair and leaned on the bed which rolled, causing him to fall. V4 stated R3 did refuse to go back to the hospital that day but ended up going the next day for evaluation and treatment. V4 and V7 stated R3's fall resulted in a broken femur, which they were also aware he refused surgical repair. V4 and V7 do not know who moved the bed or who failed to double check if the bed was locked after the resident entered the room. V4 and V7 stated the facility did an investigation and V4 made a	S9999		

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S9999	Continued From page 4 statement along with other staff working with R3 that day. When asked if R3's bed was still where it was when R3 fell on 10/13/22, they stated it had been moved one room over. At this time, this surveyor observed the bed which had been stripped down to the wire frame. It had quarter side rails and "step-on" brake pedals at the foot of the bed just above floor level. There was a green pedal to unlock the brakes and a red pedal to lock the brakes. V4 and V7 confirmed management conducted an in-service regarding locking the beds for resident safety in which they both participated. R3's progress note dated 10/09/2022 at 6:00 PM documents in part - CNA staff alerted nurse that patient did not feel well and was shaking. Upon arrival to patient's room, this nurse noted patient was indeed shaking, stated he felt sick, and that he "filled my britches." Patient had ... runny diarrhea, patient then began projectile vomiting multiple times. Set of vitals were obtained and patient was hypertensive with systolic in the 160s and diastolic >100 (greater than). This nurse contacted (V11 - Nurse Practitioner) who gave order to send resident to the ER. Upon waiting for EMS (emergency medical services), rapid COVID test was done by this nurse and resulted positive. Patient was sent to (local) hospital for eval and treatment ..." R3's progress notes dated 10/13/22 by V3 (Agency Licensed Practical Nurse - LPN) are as follows: 3:37 PM - Res readmitted to facility. Transported via ambulance; 5:20 PM - Res report he attempted to walk over to nightstand to put mail up and used bed for support. The bed rolled away from him causing him to fall. V/S (vital signs) 133/68 70-20 temp 98. res c/o (complaints of) right hip pain which he fractured last month	S9999		

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S9999	Continued From page 5 but refused to be sent for x-ray at this time; 7:15 PM - (V11 - Nurse Practitioner - NP) called regarding resident increased pain from prior fall new orders received to obtain a stat (immediate) 3 view in-house x-ray of right hip; 10:25 PM by V25 (Registered Nurse/RN) - x-ray results received showing periprosthetic fracture of the greater trochanter. V11 notified. New orders to send to ER for Eval. This nurse went to tell resident the x-ray results and to inform him of the new orders to send to ER for eval. He said absolutely not. I am staying here. I might go tomorrow morning but not tonight. This nurse tried to explain the need to go out, but resident continued to say no not tonight. V11 notified that resident would not go out for eval. She stated to make sure that ortho was notified in the AM. R3's in-house mobile x-ray report of the right hip dated 10/13/22 confirms R3 sustained a periprosthetic fracture of the greater trochanter. On 11/01/22 at 3:15 PM, V23 (Housekeeping) stated she and another staff member (she cannot recall who) were notified a resident was on their way back to the facility and were asked to move a bed. V23 stated R3 was returning from the hospital on 10/13/22 and was to be placed in a different room for quarantine. V23 stated she moved the bed to the room she was asked to move it to, then continued with her other duties. V23 confirmed R3 had yet not arrived, and she was not present when he was brought to his room. When asked what circumstance would require staff to lock or unlock a resident's bed, she stated, "I would lock/unlock a bed if the room is empty and I'm cleaning it. This would be if there was no resident assigned to that room. If a resident is assigned to a bed, I do not touch the locks, I just clean around and sweep under the bed." She stated management gave everyone	S9999		

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S9999	Continued From page 6 in-service training on locking the beds and resident safety. R3's Initial Fall and Investigation Event Report dated 10/13/22 at 5:18 PM by V3 documents - Description: Unwitnessed fall. Event Details: Resident room. What was resident doing just prior to fall? Ambulating. Was fall witnessed? No. Pain Observation: Does resident exhibit or complain of pain related to fall? If so, described location: Yes, right hip. On a scale of 0-10, how does resident rate intensity or indicate based on observation? 6 (moderate pain - distressing, miserable) ...Note any injury to the head, extremities, or trunk: No injury noted. Range of Motion (ROM): ROM painful/limited in lower extremity. Position of Extremities: No rotation/deformity/shortening noted. Level of Consciousness: Alert wakefulness - perceives the environment clearly and responds appropriately to stimuli. Facial Muscle Movement: Strong. Upper Left Extremity Movement/Grasps: Strong. Upper Right Extremity Movement/Grasps: Strong. Lower Left Extremity Movement: Strong. Lower Right Extremity Movement: Strong. Left Eye - Pupil Size/Pupil Response/Shape: 2 mm (millimeter), round/brisk. Right Eye - Pupil Size/Pupil Response/Shape: 2 mm, round/brisk ...Does resident respond to the following? Name, pain, environment. Does resident exhibit or complain of any of the following since the fall? None of the above. Mental Status: No changes. Possible Contributing Factors: Cardiac/respiratory disease. Were restraints/adaptive equipment in use at the time of the fall? None of the above. Did resident complain or experience any of the following PRIOR to the fall? None of the above. Drug Review - Does resident use any of the following types of medications? Antihypertensives, narcotics. Accidents: c. Hip	S9999		

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S9999	Continued From page 7 fracture in the last 180 days. Interventions - Immediate measures taken: Rest ...Outcome of Interventions: No interventions used ...Investigation: History of Falls? Yes ...Is the resident diabetic? No. Was edema present in extremities? No. Any recent change of condition? Yes. Describe changes noted: Covid positive/pneumonia. Has therapy evaluation been completed? No. Are any of the following in use? Wheelchair. Does resident have vision problems? Adequate ...Has resident experience or complained of dizziness? No. Does resident require assistance with transfers? Yes. Is resident continent? Yes. Was resident incontinent at time of fall? No. What equipment was in use at time of fall? Wheelchair. What footwear was in use at time of fall? Rubber sole shoes. Environmental issues identified? Room change recently ...Assessed for orthostatic hypertension. Sitting/standing BP (blood pressure): Not attempted. Conclusion with root cause: Used bed to aid in ambulation and bed rolled away from res. Additional Information: Upon further investigation and elders' statement that bed rolled away immediate action taken to verify that all beds in facility are in locked position and in-service completed with staff to ensure that beds are always in the locked position when care is not being provided: Physician notified ...Resident is his own POA (Power of Attorney). Vitals taken ...Orders to obtain a stat (immediate) 3 view x-ray of the right hip r/t (related to) fall and increased pain. Notes: 10/13/2022 5:20 PM: Res report he attempted to walk over to nightstand to put mail up and used bed for support. The bed rolled away from him causing him to fall. V/S (vital signs) 133/68 (BP) 70-20 (pulse/respirations), temp 98, res c/o right hip pain which he fractured last month but refused to be sent for x-ray at this time. Evaluation Notes: Elder initially refused to	S9999		

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S9999	Continued From page 8 go to ED (emergency department) and after eventually going to ED, refused surgical intervention/repair ... R3's progress note dated 10/14/22 at 8:30 AM documents - "Patient reporting R (right) knee and hip pain post fall yesterday. Patient requesting to be sent to the hospital. It was reported ... patient had refused to go to hospital prior to this nurse's shift. Patient will be sent to (local ER) r/t (related to) his surgeon being (at this hospital) ..." R3's progress note dated 10/17/22 at 2:33 PM reads - "Elder readmitted at this time from (local hospital) via ambulance on stretcher. Diagnosis for pelvic fracture and elder now comfort care. Pharmacy and provider notified of readmission. Reoriented to room and call light. Elder denies much pain at this time, stated "I am comfortable at the moment." On 11/01/22 at 3:00 PM, V2 (Director of Nursing - DON) and this surveyor went to the room where R3's bed currently sits. V2 pressed the green foot pedal to unlock the bed. This surveyor placed fingers on the frame and exerted light pressure at which time the bed rolled without force or resistance. V2 stated they have no facility policy regarding locking or unlocking resident beds. When asked what she would expect staff to do regarding ensuring resident beds are stable, V2 stated her expectation would be that staff would always check to make sure the resident's bed was locked and stable for safety. On 11/02/22 at 8:44 AM, V3 (Agency LPN) stated she worked in the facility on 10/13/22 and R3 was one of the residents in her care. V3 recalled that day one of the CNA's reported to her the unwitnessed fall of R3. V3 stated at the time of	S9999		

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his fall his bed was in the unlocked position. V3 stated they locked the wheels, and placed R3 in his bed so she could do his assessment. V3 stated R3 did refuse to go the ER at that time. V3 confirmed she has not worked in the facility since 10/13/22. V3 stated in her experience, resident beds are to be locked at all times unless you are actively transporting the resident in the bed for medical purposes. V3 also stated management gave in-service training on locking the beds for resident safety.

On 11/02/22 8:54 AM, V4 also stated resident beds are always locked and R3's incident on 10/13/22 was a terrible oversight. V4 stated R3 was able to get up on his own and do things, but he was assessed, and it was recommended by therapy he receive assist of 2, due to his fracture from a fall at home when he admitted, which we were doing. Again, V4 stated he was doing pretty well. R3 just leaned on the bed for support, and it rolled away from him that day. V4 stated the resident beds should always be locked unless you are transporting them somewhere in the bed.

R3's "Long-Term Care Facility and IID (Individuals with Intellectual Disabilities) - Serious Injury Incident Report" dated 10/21/22 at 9:00 PM by V2 (Director of Nursing - DON) includes - General Information: Final ...Incident Category: Fall with physical harm or injury. Resident #1 Involved in Incident: R3. Date of Birth: 03/04/26 ...Male, victim, ambulatory, wheelchair, transfer with 2. Interviewable: No. Informed Decisions: No. Alert and Oriented x 2. Capable of Communication: Yes ...Assessment by V3 (LPN) on 10/13/22 at 5:30 PM. Hospital ER (emergency room): Yes, on 10/14/22 at 8:30 AM. Admitted: Yes. Diagnosis: Femur fracture. Final Report Summary - "On 10/13/22 elder was picked up from (local) hospital

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after an acute stay for hypertension. He returned on droplet precautions for Covid-19 relating to testing positive previously on 10/10/22, so he returned in a different room. He was sitting in his wheelchair with call light within reach when he self-transferred and leaned on the bed for support when he lost his balance. Initial biotech x-ray reported fracture of right hip prosthesis. Denied going to ER at that time...the following day he complained to the nurse that he thought his knee was broke. Agreed to go to ER for further evaluation. Hospital x-ray report of the pelvis and right hip impression: There is a fracture involving the proximal femur just proximal to the stem of the femoral component of the hip replacement. There is 1.9 cm (centimeter) of medial angulation of the distal fracture fragment. 6 mm degenerative change involves the right knee. Minimal degenerative changes involve the knee. IDT (Interdisciplinary Team) met and reviewed investigation. Housekeeping and nursing departments in-service completed on 10/20/22 on ensuring beds are locked before exiting any room."

R3's facility incident investigative file included - V4's written statement dated 10/13/22 as follows - "I, (V4) arrived at work around 4:40 PM. I was told (room) had fallen on the floor. I went and got a fall mat, place it by the bed, made sure his bed was locked and lowered as low as it would go. I made sure his call light was clipped to him in reach." V5's (Agency CNA) written statement dated 10/13/22 as follows - "On 10/13/22 around 4:30 PM (room) fell on the floor. I, (V5) seen (room) on the floor by the window, the bed was not locked, he was trying to transfer to the bed from chair, he did have his w/c (wheelchair) locked. When I seen him on the floor, I asked him if he was o.k. and told him to stay put, I have to go find the

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S9999	Continued From page 11 nurse. Myself, the nurse and the other aide helped him back to the bed. We got vitals and made sure he was set in the bed. (unwitnessed fall) Resident had non-slick socks on. At the time we were passing hall trays (resident did not push call light for help, he self-transferred)." V6's (PRN CNA) written statement dated 10/13/22 as follows - "Around 4:30 PM, I, (V6) came of (different room) after helping therapy with ...I walked by R3's room and saw the nurse and (V5) getting him off the floor. I ran into help, and we found the bed wasn't locked. I locked the bed before we transferred him from the floor. He had non-slick socks on. After we transferred him from the floor, we got vitals on him. He did not put call light on for help. He self-transferred." On 11/02/22 at 11:25 AM, V14 (Restorative CNA) stated she was tasked with conducting audits once a week for 4 weeks and signing the resident roster as completed as part of the corrective action taken. She stated the audits consisted of physically checking every residents bed in the facility to ensure it was properly locked and secured so as not to roll. The last audit was completed on 10/31/22. V14 stated she continues to do bed lock checks at least once a week and verbally reminds CNAs to always check the beds to make sure they are locked before exiting the resident's room. V14 stated there are at least 3 types of beds with different lock mechanisms located on different areas of the beds in the facility. V14 stated there are foot pedal locks, tire wheel locks, and manual crank locks that lower and raise the legs of the bed. Education in-service training with return demonstration observation was given to all staff by V2 (DON - Director of Nursing) and V15 (Assistant DON). R3's facility incident file also included four facility	S9999		

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	IL6012512	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON COUNTRYSIDE MANOR	606 EAST IL HWY 15 MOUNT VERNON, IL 62864

(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
S9999	Continued From page 12 resident roster sheets dated 10/14/22, 10/21/22, 10/26/22, and 10/31/22. Each roster was signed by V14 with a handwritten note at the bottom of the sheet documenting, "All beds locked." On 11/02/22, V1 (Administrator) provided their QAPI (Quality Assurance Performance Improvement) Ad Hoc Form outlining the actions taken by the facility prior to the survey date to correct the noncompliance. Prior to the survey date, the facility took the following actions to correct the non-compliance: 1. A Quality Assurance and Performance Improvement meeting was held on 10/14/22. In attendance - V1, V2, V15, V16 (LPN/MDSC - Minimum Data Set Coordinator), and V17 (LPN/CCD - Care Plan Director). 2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: All residents have the potential to be affected. 3. Measures put into place/systematic changes to ensure the deficient practice does not recur: V3 and V15 (ADON) provided in-service to nursing staff and housekeeping regarding - ensure beds are locked prior to exiting the room. Completed on 10/20/22. All beds checked and ensured they are locked. 4. Plan to monitor performance to ensure solutions are sustained: Bed lock audits to be conducted weekly x 4 weeks by V14. The first complete facility audit was completed on 10/14/22.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 13 (A)	S9999		