STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004261	A. BUILDING: _____ B. WING _____	C 09/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDWATER CARE BLOOMINGTON	700 EAST WALNUT BLOOMINGTON, IL 61701

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S 000	Initial Comments Complaint Investigation 2367656/IL164374	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 300.1220 b)3) 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 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement IDT	S9999		

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(Inter-Disciplinary Team) and fall care planned fall interventions, failed to update the fall care plan after a fall, and failed to ensure a call light and personal belongings were within reach for one of three residents (R1) reviewed for falls with injury in the sample of three. These findings resulted in R1 falling face forward out of her wheelchair, resulting in R1 experiencing increased pain and fracturing her left femur which required surgical intervention.

Findings include:

The facility's Fall Prevention Program policy, dated 11-21-17, documents, "Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness. The fall prevention program includes the following components: Methods to identify risk factors. Care plan incorporates identification of all risk/issue, addresses each fall, interventions are changed with each fall, as appropriate, (and) preventative measures. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained. Accident/Incident Reports involving falls will be reviewed by the Interdisciplinary Team (IDT) to ensure appropriate care and services were provided and determine possible safety interventions. The Director of Nursing, or designee, is responsible for monitoring the Fall Prevention Program, including further staff education programs, purchase of additional

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equipment, or other appropriate environmental alterations. Fall/safety interventions may include by are not limited to: The nurse call light device will be placed within the resident's reach at all times. The resident's personal possessions will be maintained within reach when possible. Residents who require staff assistance will not be left alone after being assisted to bathe, shower, or toilet. Nursing personnel will be informed of residents who are at risk of falling. The fall risk interventions will be identified on the care plan. The frequency of safety monitoring will be determined by the resident's risk factors and plan of care. In the event safety monitoring is initiated for 15-30-minute periods, a documentation record will be used to validate observations."

R1's Order Summary Report, dated 9-22-23, documents R1 is an 83-year-old with the diagnoses of Chronic Instability of the Knee, Mild Intellectual Disabilities, History of Falling, Syncope and Collapse, Morbid Severe Obesity, Cognitive Communication Deficit, Chronic Pain, Abnormal Posture, Fracture of the Left Femur with subsequent encounter for Closes Fracture, and Hypertension.

R1's Fall Plan of Care, dated 9-20-23, documents the following fall interventions: "Be sure my call light is within easy reach for me and encourage me to use it for assistance as needed. Ensure all my personal items are in easy reach and not on the floor."

R1's MDS (Minimum Data Set) Assessment, dated 8-13-23, documents R1 is cognitively intact, requires extensive assistance with transfers, bed mobility, and toileting. This same MDS documents R1 has had no falls between 5-13-23 and 8-13-23.

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R1's Witnesses Fall Report, dated 8-18-23 at 9:30 PM, and signed by V6, (LPN/Licensed Practical Nurse) documents, "Resident in spa room with CNA (Certified Nursing Assistant) assisting (R1) being re-positioned in wheelchair and (R1) fell forward and hit face on toilet seat. Immediate Action Taken: Re-positioned in wheelchair and taken back to her room and placed in bed. Injury Location: Bruise to face."

R1's IDT (Inter-Disciplinary Team) Health Status Note, dated 8-21-23 at 11:28 AM, documents, "8-18-23 resident fall was witnessed by staff in restroom. (R1) reached for sink and slid out of wheelchair, hitting her face on the sink. (R1) did have a bloody nose and bruising to the right side of her face. (V4/R1's Physician) notified. Care plan updated. CS (Central Supply) to work on ordering (R1) a seatbelt or chest harness for additional support for resident to not slide out of wheelchair. Assessment will be performed on (R1) and new belt to make sure (R1) can release herself prior to initiating assistive device."

R1's Comprehensive Care Plan, dated 9-20-23, does not include any documentation regarding R1's fall on 8-18-23, or a revision to update or revise R1's fall interventions following R1's fall on 8-18-23.

R1's Progress Notes, dated 8-27-23 at 11:00 AM, document, "(R1) found in floor in her room. (R1) states she was reaching for her book and fell forward from her wheelchair. Found face forward with left leg bent under her. (R1) Hoyer (mechanical lift) back to bed. (R1) complains of pain in left knee on little movement."

R1's Progress Notes, dated 8-27-23 at 11:20 AM,

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document R1 was sent to the hospital for increased complaints of pain to the left knee.

R1's Hospital Emergency Department Notes, dated 8-27-23, document, "(R1) arrived at the emergency department for left leg pain after falling out of her wheelchair this morning", and R1 was complaining of left anterior lower jaw pain and left leg pain. These same notes document R1 had a fall a week prior resulting in a facial injury. `

R1's X-Ray Left Femur, dated 8-27-23, documents, "Findings: Displaced and mildly angulated distal left femoral (left thigh) fracture. Left hip osteoarthritis."

R1's Operative Procedure Note, dated 8-31-23, documents R1 had an open reduction and internal fixation of the femur shaft fracture with intramedullary (inner tissue) implant.

R1's Final Report to Public Health Department, dated 9-5-23 and signed by V1 (Administrator) and V2 (Director of Nursing) documents, "On 8-27-23 (R1) was observed on the floor in resident's room. Upon assessment (R1) stated that she was reaching for her book and fell forward in her wheelchair. (R1) was mechanically lifted back to bed with assist of two clinical staff members, offered pain medication, leg immobilizer, and ice applied. (R1) assessed further and complaints of pain to left knee. (V4/R1's Primary Physician) was called and order obtained to send (R1) to emergency department for evaluation. (R1) was admitted to hospital and was not returned to facility at this time. Conclusion: Surgery to repair (R1's) left hip was postponed due to diagnosis of sepsis due to aspiration pneumonia. (R1) had a recent decline

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prior to the fall and diet was changed to pureed after speech therapy evaluation on 8-1-23. Postoperative Diagnosis: Open reduction internal fixation of left distal femur peri-prosthetic fracture."

On 9-22-23 at 9:10 AM, R1 was sitting in a high back padded chair with the foot of the chair elevated and R1's legs elevated. R1 had a bedside table across the front of her and was eating breakfast. R1 had non-skid socks on and a non-skid pad under her buttocks. R1 stated, "The day I fell (8-27-23), I was brushing my teeth and fell forward out of my chair. I am top heavy and have fell (sic) out of my chair several times. I broke my knee when I fell. The staff was just in my room right before I fell. I am in no pain right now."

On 9-22-23 from 11:25 AM to 11:52 AM, R1 was sitting in her room in a high back padded chair with the foot of the chair elevated and R1's legs elevated. R1 was not in reach of her call light or belongings, and was approximately four feet away from her bed, call light, and bedside table. R1 was fidgety and moving her feet.

On 9-22-23 at 10:00 AM, V5 (CNA/Certified Nursing Assistant) stated, "I was taking care of (R1) on the day she fell (8-27-23). I had just taken (R1) to the toilet and left her in her room in her wheelchair. I came out of another resident's room and saw (R1) laying on the floor in front of her wheelchair. (R1) had fell (sic) forward out of her wheelchair and her legs were crossed under her. I immediately yelled at staff to get the nurse. The nurse (V6/Licensed Practical Nurse/LPN) came in the room and assessed (R1) and we noticed (R1's) left knee looked out of place. (V6) called 911 while I stayed with (R1) and then the

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S9999	Continued From page 7 ambulance came and took (R1) to the hospital. I did not notice (R1) to have any other injuries." On 9-22-23 at 11:52 AM, V5 (CNA) stated, "I took (R1) to her room today and left her in her chair while I went to find help and get the (mechanical lift). I guess I must have left her in there without her call light. I really did not think about it." On 9-22-23 at 11:05 AM, V2 (Director of Nursing) stated, "The IDT team did not meet about (R1's) fall on 8-18-23 (Friday) until 8-21-23 (Monday). The IDT team does not meet about falls over the weekend until Mondays. There were no fall interventions put into place after (R1's) fall on 8-18-23 from the nurse that I am aware of. I did not realize nurses could update the care plans with new fall interventions. The IDT team met on 8-21-23, and decided to order a self-releasing harness for (R1) to keep her from falling out of her wheelchair. I do not believe we (the facility) ever received the harness before (R1) fell out of her wheelchair again on 8-27-23. I know (R1) has had multiple falls from slipping out or falling forward out of her wheelchair. The IDT did not re-evaluate (R1's) fall interventions or put anything else into place while we were waiting on the harness. (R1's) fall care plan does not include documentation or interventions addressing (R1's) fall on 8-17-23." On 9-22-23 at 11:55 AM, V6 (LPN) stated, "I was (R1's) nurse both times (R1) fell (8-17-23 and 8-27-23). I do not recall doing any fall interventions following (R1's) fall on 8-17-23. (R1) fell face first out of her wheelchair and had a bloody nose. I did not know I could implement fall interventions or document on the care plan. The only thing different we (the facility) did was do neurological checks for 72 hours after her fall on	S9999		

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S9999	Continued From page 8 8-17-23. (R1) fell face first out of her chair on 8-27-23 and I sent her to the emergency room immediately. (R1) broke her leg. (R1) did not have any kind of harness or seat belt on when she fell on 8-27-23." On 9-22-23 at 12:00 PM, V2 stated, "(R1) should not have been left in her room without her call light or other belongings in reach." On 9-22-23 at 12:00 PM, V1 (Administrator) stated, "(V5) should not have left (R1) in her room without her call light within reach. (V5) will need to be disciplined." (A)	S9999		