STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003933	A. BUILDING: _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALLMARK HEALTHCARE OF PEKIN	2501 ALLENTOWN ROAD PEKIN, IL 61554

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

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S9999	Continued From page 1 These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide supervision to a cognitively impaired resident with a history of falling, for one of one resident reviewed (R55) for falls with major injury. This failure resulted in R55 falling from her wheelchair as she was unsupervised, on 8/06/23 and sustaining a left hip fracture. Findings include: On 8/21/23 at 11:54 am, R55 was sitting in a high back reclining wheelchair with a lap tray. R55 was non-verbal and leaning forward with her head resting on the lap tray. On 8/22/23 at 10:23 am, R55 was sleeping in bed with a staff member sitting in the doorway providing 1:1 supervision. The Electronic Record Face Sheet documents R55 was admitted to the facility on 6/16/23 with the diagnoses of Non-displaced Fracture of the Second Cervical Vertebra with Subsequent Encounter for Fracture with Routine Healing, Aftercare Following Surgery on the Nervous System, Encephalopathy, History of Falling and Major Depressive Disorder. A Fall Risk Assessment completed 6/16/23 determined R55 to be high risk for falls. Nursing Notes, dated 6/17/23, document R55 was transferred to the local Hospital for chest pain, was admitted for Pneumonia, Urinary Tract Infection and Acute Metabolic Encephalopathy and did not return to the facility until 7/10/23. R55's 7/10/23 Hospital Transfer/Readmission documentation indicates R55 was started on Seroquel (Anti-psychotic) 25 mg (milligrams) daily during that hospitalization and orders were given for R55 to continue the	S9999		

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S9999	Continued From page 2 Seroquel 25 mg daily. A repeat Fall Risk Assessment on 7/10/23 documents R55 continued to be high risk for falling. R55's Plan of Care, which was revised on 7/13/23 documents "(R55) is at risk for falls and injuries (related to) a (history) of falls prior to admission, use of narcotics for pain control, poor safety awareness secondary to (a diagnosis) of Dementia, daily use of Psychotropic medication, daily use of Antipsychotic medication and age. (R55) gets agitated when staff try to redirect her." Nursing Progress Notes document R55 fell a total of eight times between 7/14/23 and 8/03/23. Physician's Orders document R55's Anti-psychotic medication, Seroquel was doubled in dose to 25 mg twice per day (on 7/19/23), an additional Anti-psychotic, Zyprexa 2.5 mg daily was added on 7/28/23. Physician's orders document R55's Seroquel was doubled again on 7/29/23, to 50 mg twice per day. Manufacture's Prescribing Information cites patients on Seroquel are at an increased risk of sedation, somnolence and dizziness, which could lead to falling. Fall Investigations indicate R55 experienced her first fall at the facility on 7/14/23, when R55 was witnessed by staff to stand from her wheelchair, land on her buttocks when she went to sit down, sustaining no injury. The next Fall Investigation, dated 7/15/23, documents R55 was observed by staff to stand from the dining room table, lose her balance and fall to the ground, without injury. The 7/15/23 Fall Investigation determined R55 was barefoot when she fell and needed to always have proper footwear on. A Fall Investigation, dated 7/17/23, documented R55 experienced an unwitnessed fall and was found, uninjured, by staff sitting on the floor in front of her wheelchair in the dining room. Documentation indicates the facility put a Dycem (non-slip pad) in the seat and	S9999		

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S9999	Continued From page 3 added an anti-roll back devices to R55's wheelchair. A 7/18/23 Fall Investigation documented R55 was found lying on her side in the hallway and the fall was unwitnessed. The 7/18/23 Fall Investigation determined R55 was uninjured and had likely wandered into the hallway looking for a bathroom, so a nightlight was placed in R55's room and she was to be encouraged to toilet prior to bedtime. Another Fall Investigation, dated 7/23/23, documents staff observed R55 stand from her wheelchair and then kneel onto the floor before staff could assist her. The 7/23/23 Fall Investigation determined R55 was restless in the dining room, stood independently and was uninjured, with instructions for staff to offer R55 to lay down in bed between meals. A Fall Investigation, dated 7/30/23, documents staff observed R55 standing next to her wheelchair, turn and fall onto her right side, sustaining a skin tear to her right wrist and a "bump" to the left side of her head. The 7/30/23 Fall Investigation determined "Resident has Dementia and is confused. Attempted to stand from chair without assistance," with an intervention of a pressure alarm to be placed in R55's wheelchair. Another Fall Investigation, dated 8/02/23, documents staff observed R55 get up out of her wheelchair and fall to the floor, without sustaining an injury. The 8/02/23 Fall Investigation determined R55 attempted to stand unassisted and lost her balance, with an intervention of "Supervision will be increased by way of sitting at the nurse's station and management offices with staff and engaging in meaningful conversation." A Fall Investigation, dated 8/03/23, documents staff witnessed R55 standing in the hallway with her wheelchair behind her as she fell backwards onto her buttocks. The 8/03/23 Fall Investigation concluded that R55 was uninjured, has "poor	S9999		

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S9999	Continued From page 4	S9999		

safety awareness due to Dementia" and recommended applying a soft lap restraint "to keep (R55) safe from falls." Lastly, a Fall Investigation, dated 8/06/23 at 11:20 am, documents, "This nurse was notified by (resident's Certified Nursing Assistant) that this resident had a fall out in the hallway. This nurse witnessed resident on the ground next to wheelchair with (Certified Nursing Assistant) and staff present at the scene. (R55) unable to state what happen(ed) and if she is experiencing any pain. (R55) unable to give description. Vitals (within normal limits). No injuries noted. (R55) unable to state any pain. No visible sign of trauma noted. Skin intact. Oriented to self. (R55) is now being (placed) on 1:1 supervision by staff." Nursing Notes from 8/06/23 document R55 had displayed "signs of discomfort during transfer to bed" at 9:00 pm, and at "Around (11:00 pm) CNA (Certified Nursing Assistant) told nurse (R55) continued to display signs of pain during bed check. Resident held her left hip while lying down while grimacing, so nurse called to have resident sent to (local Hospital) to have her hip (x-rayed)." Hospital Records, dated 8/07/23, document R55 was found to have an "acute, displaced, overriding subcapital left femoral neck fracture with overriding at the fracture site." The Hospitalist Discharge Summary, dated 8/10/23, documents "Family opted against surgery (of femoral neck fracture) and instead wanted her moved to palliative/comfort care, had agitation related to Dementia, being in new setting, etc."

An Administrative Summary/Verification of Incident Investigation dated 8/06/23, documents "(R55) had a fall in the hallway out of her wheelchair, not witnessed. Resident was unable to state what she was doing, due to her cognitive status. She was likely attempting to get out of

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S9999	Continued From page 5 (her) wheelchair to ambulate unassisted. The nurse immediately assessed resident, and vital signs (were) completed. (R55) had no noted abnormalities, edema, redness, and no open areas, so she was assisted back to (her) wheelchair per staff. (R55) continued with 1 on 1 supervision by (Certified Nursing Assistant). (R55) was being transferred to bed by staff later that night and she was noted to show signs of discomfort. The nurse completed assessment and sent resident to Hospital for an evaluation related to her signs and symptoms of pain during weight bearing activities. (R55) was diagnosed with a left hip fracture and returned to the facility." A witness statement, from V18 (Certified Nursing Assistant), dated 8/07/23, documents "I don't remember exactly what time I actually toileted the resident that day, but when I take care of her, I normally attempt to take her to the bathroom every hour or hour and a half. That day, I went to break and let the nurse know I was leaving the unit. When I came back on the unit, I saw (R55) laying in the hallway. I was gone approximately 15 minutes. (R55) was a couple feet from her wheelchair, so it appeared she may have tried to ambulate without assistance. I immediately went and got the nurse." On 8/24/23 at 11:40 am, V2 (Director of Nursing) stated R55 had repeatedly fallen because she would stand from her chair and try to ambulate independently. V2 stated R55 could only ambulate with a gait belt and standby assistance of staff. V2 stated they tried using a soft lap restraint in R55's wheelchair to remind her she shouldn't stand independently, but R55 would just pull it off the wheelchair and throw it. V2 stated they tried using a pressure alarm in the seat of R55's wheelchair, but that agitated R55, and she would turn it off. V2 indicated, this was when they	S9999		

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S9999	Continued From page 6 decided R55 should be at the Nurse's Station for increased supervision by staff when up in her wheelchair. V2 stated she would expect staff to have R55 within arm's reach, not just visual supervision. V2 stated her investigation into the 8/06/23 fall concluded that R55 was in the hallway by the Social Service office, and not at the Nurse's Station when she fell. According to V2, based on the location of where R55 was found on the floor and the location of her wheelchair, it appeared R55 had stood from her chair and taken a couple of steps and then fell. V2 stated, even if R55 had been left at the Nurse's Station, she needed to be monitored because she would propel away, "so, someone had to watch her." V2 confirmed that V18 had left the unit for break at the time of R55 fall and there was no staff around to witness the incident. On 8/24/23 at 1:19 pm, V10 (Licensed Practical Nurse) stated she was R55's nurse on 8/06/23. V10 stated she gave R55 her medication around 11:00 am, and at that time R55 was sitting in her wheelchair in the hallway near the Social Service office. V10 didn't recall any additional staff in the area at that time. V10 then took her medication cart into the dining room to finish her medication pass. V10 indicated, several minutes later, she heard V18 (Certified Nursing Assistant) say R55 was on the floor. V10 stated she assessed R55 for injury and R55 did not express any verbal or non-verbal indicators of pain, so they assisted R55 back into her wheelchair. V10 stated she then took R55 into the dining room with her so she could monitor her more closely. V10 stated staff are to watch R55 closely, because she "needs constant supervision, she likes to get up (on her own)." V10 stated she was unaware that V18 had been out on break when R55 fell and indicated if she had known, she would have	S9999		

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S9999	Continued From page 7 "brought her (R55) with me on my med (medication) pass." V10 stated she was unaware that R55 had been care planned to be at the Nurse's Station for increased supervision, as well. (A)	S9999		