STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

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S 000	Initial Comments Complaint Investigation: 2320741/IL155796	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)5) 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. 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) 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. 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. 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		

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S9999	Continued From page 2 These requirements were not met as evidenced by: Based on observation, record review and interview the facility failed to implement appropriate person centered fall interventions. This failure resulted in multiple falls with injuries for two residents (R1, R2) reviewed for falls in a sample of three. This failure resulted R2 requiring medical attention for head lacerations and hematomas at the local hospital on multiple occasions. Findings include: Facility Fall Policy, revised 8/1/22, documents: It is the policy of this Facility to provide guidelines for the appropriate handling of a resident's fall, accident or incident; and each situation must be handled in the manner that is most appropriate at the time and for the nature of the change in condition. Facility Fall Monthly Tracking Logs, dated 1/1/23 through 1/31/23, were reviewed. The Fall Log documents that R1 had falls two falls on 1/14/23, and one fall on 1/17/23 and 1/28/23. The Fall Log documents that R2 had two falls on 1/9/23, and one fall on 1/11/23, 1/12/23, 1/14/23 and 1/30/23. 1. R2's current Care Plan documents that R2 has diagnoses including Osteoarthritis, Chronic Obstructive Pulmonary Disease, Unspecified Abnormalities of Gait and Mobility. R2's Minimum Data Set/MDS dated 12/29/22,	S9999		

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S9999	Continued From page 3	S9999		

documents R2 has a Brief Intermittent Mental Status/BIMS (score of 13/15) showing that R2 has minimal cognitive impairment. R2's MDS also documents that R2 requires extensive staff assistance of two persons for bed mobility and transferring and extensive staff assistance of one person for toileting.

R2's Fall Report, dated 1/7/23 at 2:45 pm, documents that R1 had an unwitnessed fall while self ambulating with a wheeled walker in R2's room. R2 stated, "I caught the edge of the bed and I fell over." R2 sustained two skin tears, one on each leg, and the skin tears were cleansed and bandaged. R2's Medication Administration and Treatment Administration Record does not document Physician Orders for treatment or monitoring of R2's skin tears. R2's current Care Plan documents an intervention of ensure the call light is in reach.

R2's Fall Report documents that R2 had an unwitnessed fall on 1/9/23 at 12:15 pm. R2 was found on the "floor with buttocks with back against her bed, overhead table was over resident, and resident's legs were over the bottom bar of the overhead table." The intervention was educated on the need for calling for assistance.

R2's Fall Report documents that R2 had an unwitnessed fall on 1/9/23 at 8:45 pm. R2 was taking self to bathroom and fell backwards in room. R2 was found lying on back with walker at bedside and bleeding noted under R2's head. R2 sustained a one centimeter/cm laceration to the posterior left side of the head with a golf ball size hematoma. R2 stated, "I was going to the bathroom and fell backwards." R2 denied dizziness and R2's blood pressure was 150/86.

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S9999	Continued From page 4 The intervention was for orthostatic blood pressure checks for three days. R2 was sent to the local hospital for evaluation and treatment and returned to the facility with four staples to the laceration. The Facility Local Health Department Serious Incident Report, dated 1/10/23, documents that R2 sustained a fall on 1/9/23 at 8:45 pm. R2 was "discovered on the floor of her room" with "her walker lying to her side and had a laceration to the back of her head." R2 was returning from "the bathroom and fell backwards striking her head on the floor." R2 was sent out to the local Hospital's Emergency Department for evaluation and returned to the facility with four staples to the laceration to the back of R2's head. The Report documents that R2 has a secondary diagnosis including abnormalities of gait and mobility. R2's Hospital Emergency Department Discharge Instructions, dated 1/9/23, documents that R2 was evaluated for a head laceration due to a fall. R2 received staples to the head laceration. Orders were received that R2 should have the staples removed in seven to ten days and should be evaluated in one to two days for redness or drainage. R2's Fall Report, dated 1/11/23 at 6:30 am, documents that R2 sustained an unwitnessed fall while self transferring to the bathroom. R2 was noted to be laying on the left side with legs wrapped around the legs of R2's walker. R2 was wearing non-slip socks and R2's call light was not activated. No injuries were noted and R2's current Care Plan documents that R2 was moved closer to the nurses station for monitoring. R2's Fall Report, dated 1/11/23 at 3:15 pm,	S9999		

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S9999	Continued From page 5	S9999		

documents that R2 sustained a staff assisted lowering to the floor fall. R2 was ambulating with staff to the smoking break with a wheeled walker. R2 stated, "My leg got weak and I could not make it any further. No injuries were noted and R2's current Care Plan documents an intervention of R2 using a wheelchair to go outside to smoke.

R2's Fall Report, dated 1/14/23 at 11:10 pm, documents that R2 sustained an unwitnessed fall. A "loud crash" was heard and R2 was noted to be laying on the floor by the bathroom door. R2 was noted to have a laceration on the back of R2's head with a moderate amount of bleeding. R2 was sent to the local hospital for evaluation and treatment. R2 returned to the Facility with a treatment (Dermabond) to the laceration. A CT was performed and all results were negative. R2's current Care Plan documents an intervention of "Call Don't Fall" signs to be placed in R2's room. R2's Physician Order Sheet, Medication Administration and Treatment Administration Sheets and Nursing Notes do not document Physician Orders for treatment or monitoring of R2's laceration.

The Facility Local Health Department Serious Incident Report, dated 1/15/23, documents that R2 sustained a fall on 1/14/23. R2 was noted to be on the floor by the bathroom. R2's "walker was on the floor next to her and no other trip hazards were identified. (R2) was assessed and noted to have a small laceration to the upper posterior aspect of her head which was bleeding." R2 was sent to the local Hospital's Emergency Department for evaluation and treatment. R2's laceration was glued (Dermabond) and R2 returned to the facility. R2 had slipper socks on and R2's call light was not activated at the time of the incident. R2's Hospital Computed

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S9999	Continued From page 6 Tomography/CT Report, dated 1/15/23, documents that R2 had a CT and the impression was that R2 had a left posterior parietal scalp hematoma. R2's Hospital Emergency Department Discharge Instructions, dated 1/15/23, documents that R2 was evaluated for a ground level fall and a laceration of the occipital region of the scalp. R2's Fall Report, dated 1/30/23 at 10:35 am, documents that R2 sustained an unwitnessed fall. R2 was found sitting on buttock next to R2's bed. R2 stated, "I was trying to get my phone charger." R2 stated that R2 hit head. R2 was sent to the local hospital for evaluation and treatment. A CT of the head was performed with no findings and returned to the Facility. R2's current Care Plan documents an intervention to make sure that items are within reach of resident. R2's Hospital Emergency Department Discharge Instructions, dated 1/30/23, documents that R2 was evaluated for a closed head injury due to a fall sustained on 1/30/23. The Commuted Tomography (CT) results show a scalp hematoma. On 1/31/23, at 12:05 pm, R2 had a laceration to the back of the head with dark brown appearance and matted uncombed hair. R2 stated, "I have tripped over my walker and stuff before and had a few falls that sent me to the hospital. The last time I went I had to get another gash 'glued.'" On 1/31/23, at 11:01 am, V5 (Assistant Director of Nursing/DON) stated, "For (R2's) first fall on	S9999		

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S9999	Continued From page 7 1/7/23, the intervention was to make sure that the call light was in reach. Then (R2) had two falls on 1/9/23, and the intervention for the fall at 1/9/23 at 12:15 pm, we educated on the need for calling for assistance. Then for the 1/9/23 at 8:45 pm fall, we thought maybe (R2's) blood pressure was dropping when (R2) stood up, so the intervention was for orthostatic blood pressure's for three days. Obviously, the first two interventions did not work because (R2) was not asking for help or activating the call light. (R2's) legs would give out and that is why (R2) fell on 1/11/23. I am not sure why (R2) was not asking for help or putting on her call light. I am not sure if some of these interventions were right for her, because she kept falling. It is hard to do the right intervention." On 2/1/23 at 11:30 am, V5 (Assistant Director of Nursing/DON) stated, "Some of the interventions were probably not the best but it is difficult to find the right intervention sometimes. I understand that you should not use things like education and stuff when finding an intervention for a confused person, that is probably not the best intervention." 2. R1's current Care Plan documents that R1 has diagnoses including Hemiplegia and Hemiparesis, unspecified Cerebrovascular Disease affecting Left Non-Dominant side; History of Falling, other Symptoms and Signs involving the Musculoskeletal System, other Symptoms and Signs involving Cognitive Functions and Awareness and Dementia. R1's Minimum Data Set/MDS dated 12/30/22, documents that R1 has a Brief Intermittent Mental Status/BIMS (score of 0/15) showing that R1 is rarely or never understood and has moderately impaired cognitive skills for daily decision making.	S9999		

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S9999	Continued From page 8 The MDS also documents that R1 requires staff assistance of one person for bed mobility, transferring and toileting. R1's Fall Report, dated 1/14/23 at 3:15 pm, documents that R1 had an unwitnessed fall while transferring self to the bathroom and was noted sitting on her bathroom floor. R1's current Care Plan documents that the intervention was frequent checks. R1's Fall Report, dated 1/14/23 at 6:45 pm, documents that R1 had an unwitnessed fall while self transferring to bed. R1 was noted on the floor in front of wheelchair in between the bed and window. R1 was unable to recall the events. R1's Care Plan documents that Gripper strips were placed on the side of the bed on the door side. R1's Fall Report, dated 1/17/23 at 8:00 pm, documents that R1 had a witnessed fall. R1 was laying on left side with head on bedside table leg with bleeding noted above the left eye. R1 had support stockings on and R1's slipper socks were on the floor. Noted that R1's call light was not activated but within reach. R1's Nursing Note documents that on 1/18/23, at 2:46 pm, V7 (R1's Physician) was notified of R1 not extending the right lower extremity and grabbing right thigh in pain. Requesting an order for an X-Ray. V7 stated, "It is okay to do an X-ray but X-rays usually do not show fractures. If the X-ray comes back okay and (R1) is still having pain, get a Commuted Tomography (CT) without contrast." R1's Nursing Notes and Medication Administration Records, dated 1/17/23 through 1/27/23 document R1 receiving pain medication. R1's Medical Record does not document an order	S9999		

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S9999	Continued From page 9 for a CT or CT results. R1's Fall Report, dated 1/28/23 at 11:08 am, documents that R1 had an unwitnessed fall out of bed. R1 was noted to be on the floor next to R1's bed on the right side. R1's current Care Plan documents that R1 to be positioned in the center of the bed. On 2/1/23, at 11:44 am, V8 (Registered Nurse) stated, "When a resident falls, we should try and put the right intervention in to place, sometimes it is hard, especially when someone falls a lot. We fax the Doctor and do a Risk Management Form that gets reviewed by the Department Heads for appropriate interventions. Sometimes we do not hear right back from the Doctor." On 2/1/23, at 10:26 am, V7 (Medical Director) stated, "Sometimes I do not get notification of falls until many days later, we are trying to work on this. so that Residents can be treated and monitored adequately. Sometimes I do not get notification of a fall until days later. The Facility should be making the appropriate interventions on an individualized case by case. We are trying to work together to find the right cause of the falls, I have really been looking at the Gradual Dose Reductions of Medications that the Facilities keep wanting to put people on too." (B)	S9999		