Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004790	A. BUILDING: _____ B. WING _____	C 04/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	200 FAIRMAN AVENUE WATSEKA, IL 60970

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S 000	Initial Comments Complaint Investigation 2362681/IL158200	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210c) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to adequately supervise a cognitively impaired resident and maintain a bed alarm in proper working condition. This failure resulted in R1 sustaining Thoracic-10 and Lumbar-2 (spinal) fractures. The facility also failed to utilize the Physician Ordered full mechanical lift to provide a safe transfer for a R3, resulting in a fall. R1 and R3 are two of three residents reviewed for falls on the sample list of six.

Findings include:

1. R1's Physician Order Sheet (POS) dated 4/7/23 documents the following diagnoses: Altered Mental Status, Long Term Current Use of Aspirin, Repeated Falls, Unspecified Dementia

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Unspecified Severity, Osteoporosis and Anxiety. The same POS documents: "Bed sensor pad on bed at HS (Bedtime) d/t (due to) poor sitting balance in bed/awareness, weakness, unsteady gait, inability to transfer self. Check every shift to ensure sensor pad is working. Start date 01/18/2021."

R1's Minimum Data Set (MDS) dated 1/2/23 documents the following: R1 has a Brief Interview for Mental Status score of 2 out of 15 indicating severe cognitive impairment. The same MDS documents R1 requires physical staff assistance with transfers, ambulation and toileting.

R1's Nurses Note dated 12/24/2022 at 03:32 am documents the following: "Note Text: Roommate (unidentified) alerted staff of resident (R1) fall (,) resident on floor in bathroom (,) on right side (.) residents alarm did not sound (.) no injuries present (,) neuros (neurological assessment) and vitals initiated (,) resident (R1) assisted to bed (,) alarm replaced and working (.) resident reminded to use call light."

R1's Health Status Note dated 12/28/2022 at 10:15 am documents the following:
"Note Text: Resident (R1) ambulated to shower room with staff assist-writer called to shower room per CNA (Certified Nursing Assistant) (unidentified)-noted purple/yellow fading bruising across mid chest to top of breasts-resident denies discomfort. Had last fall 12/24/22 which was unwitnessed. DON (V2/Director of Nursing) notified."

R1's Nurses Note dated 12/29/2022 at 11:54 am documents the following: "Note Text: Follow up on C-Xray (Chest X-ray). (V20/Physician) notified of new compression fracture of T10 and L2 (thoracic

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and lumbar region of the spine). (V20) would like the family (V27) POA to give a go-ahead for the treatment. (V20) states fosamax (Fosamax) 70 mg wkly (weekly) will be given for treatment of osteoporosis. (V27/R1's Family Member) notified and he gave a go-ahead for the said treatment. (V20) notified."

R1's "Post Fall Assessment" dated 12/24/22 documents the following: "Resident observed on the floor in the bathroom on right side. Walker nearby. Roommate (unidentified) saw resident (R1) melt into the floor. She (R1) did not hit her head." The same Post Fall Assessment documents: "Bed Alarm did not sound during event. Not working. Got new alarm."

On 4/7/23 at 10:15 am V2 (Director of Nursing/DON) stated, "(R1's) chest bruise 12/28/22 was determined to be from her fall 12/24/22 and not of an unknown origin. The X-ray done 12/28/22 showed she suffered the fractures (Thoracic-10 and Lumbar-2). The root cause of the fall was ambulating without assistance, and malfunction of the bed alarm. The staff know she (R1) has a history of falls, putting her at high fall risk for subsequent falls and requires frequent visuals."

On 4/7/23 at 12:50 pm V2 (DON) provided a copy of the facility "Sensory Alarm Checklist." V2 reviewed the list and stated, "There is really no way to determine if the bed alarm was confirmed to be in working order before the fall. The 'Sensor Alarm Checklist' only has the staff check off if the resident has an alarm. I will be updating the form to make sure it identifies if the alarm was working or if the batteries were changed. It was determined (R1's) bed alarm had to be replaced. It was not a battery issue."

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The facility "Sensor Alarm Checklist" dated 1/4/23 documents the following: "Please check to make sure alarms are in place and are functioning properly. If alarm is not functioning, replace batteries and cord to sensor pad. Replace immediately if not working. The same 'Sensor Alarm Checklist' documents check-boxes that are labeled "Bed, Recliner, Chair" to indicate the presence of the alarm. There is not a designated box to indicate if the alarm is functioning properly or if there was a need to replace the batteries.

2. R3's Physician Order Sheet (POS) dated April 2023 documents R3 is diagnosed with Paraplegia, Muscle Weakness, and Falls. The same POS documents starting 1/4/23, R3 was to be transferred with a full mechanical lift.

R3's Morse Fall Scale dated 12/29/22 documents R3 is a high risk for falls related to him fallen before, uses ambulatory aides, and he overestimates or forgets limits.

R3's Post Fall Assessment dated 3/10/23 documents R3 was being transferred from the bedside commode to the recliner and when he was unhooked from the sit to stand mechanical lift he slid out of the recliner to the floor.

On 4/4/23 at 12:00 PM, R3 stated he fell onto the floor from the recliner when he was unhooked from the sit to stand mechanical lift. R3 stated he was sitting too close to the edge of the chair.

On 4/5/23 at 10:32 AM V11 (CNA) stated on 3/10/23 that she and V9 (CNA) transferred R3 using the sit to stand mechanical lift. V11 stated R3 started to get weak and pass out and they lowered him to the recliner. V11 stated as soon

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S9999	Continued From page 5 as they began to unhook the support strap on the lift, R3 slid to the floor. V11 stated they must have sat R3 down too close to the edge of the chair which caused him to slip off. V11 stated as far as V11 knew, R3 was to be transferred with the sit to stand mechanical lift at the time. On 4/5/23 at 10:51 AM V9 (CNA) stated on 3/10/23 she and V11 (CNA) transferred R3 using the sit to stand mechanical lift. V9 stated R3 started to get weak and pass out and they lowered him to the recliner. V9 stated when they unhooked the support strap on the lift, R3 slid to the floor. V9 confirmed they must have sat R3 down to close to the edge of the chair which caused him to slip off. V9 stated as far as V9 knew, R3 was to be transferred with the sit to stand mechanical lift at the time. On 4/7/23 at 2:10 PM V2 (DON) confirmed R3 had an order to be transferred with a full mechanical lift and on 3/10/23 R3 was transferred with a sit to stand mechanical lift. V2 also confirmed that V9 and V11 should have made sure R3 was sitting back safely in the recliner before unhooking the support strap on the mechanical lift. This might have prevented him sliding onto the floor. The facility's Fall Prevention Program dated 8/29/22 documents staff should provide ongoing risk reducing interventions, initiate physician orders as needed, identify and implement related care link interventions, and provide ongoing evaluation of resident response to interventions. (B)	S9999		