STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008510	A. BUILDING: _____ B. WING _____	C 06/28/2023

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ARC AT NORMAL,THE	509 NORTH ADELAIDE NORMAL, IL 61761

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S 000	Initial Comments FRI of 6/15/2023/IL161310	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 Requirments were not met as evidenced by: Based on observation, interview and record review, the facility failed to communicate a resident's fall risk and safety needs to prevent a fall, thoroughly investigate a fall, care plan resident's fall risk and implement post fall interventions for three of three residents (R1, R2, R3) reviewed for falls on the sample list of three. This failure resulted in R1 falling after getting up and ambulating independently, and sustaining a severe intracranial hemorrhage that resulted in R1's death. Findings Include: The facility Fall Assessment and Management Policy April 2019 documents it is the policy of this facility to assess each resident's fall risk on admission, quarterly, and with each fall. This will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk. Factors related to the risk will be addressed and care planned. The potential for falls will be care planned when	S9999		

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S9999	Continued From page 2	S9999		

appropriate, based on the results of the Fall Risk Assessment. The interdisciplinary care plan will be person centered to reflect the specific needs and risk factor of the resident. Interventions will be based on the fall risk assessment and the circumstances surrounding the risk for injury or actual injury or fall. After a fall, a licensed nurse will consult with the resident's care givers and other interdisciplinary team members in regards to future intervention, and resident specific risk factors. The resident and family will be involved in the care planning process whenever possible.

1.) R1's Fall Risk Assessment dated 6/14/23 documents R1 is at moderate risk for falls.

R1's Care Plan dated 6/14/23 documents R1 is at risk for falls related to having a recent fall history and significant decline physically. The only fall prevention intervention documented at this time is to make sure the call light is within reach.

R1's Progress Notes dated 6/14/23 document R1 was admitted to the facility on 6/14/23 at 6:30 pm via ambulance. These notes also document R1's family informed V3 Agency LPN about R1's safety needs: R1 is a high fall risk with frequent intermittent confusion and requested R1 not take the ordered Eliquis (blood thinner) due to R1's frequent falls and prolonged bleeding. V1 stated V11 provided most day to day care for R1 and requested that R1 be toileted at 1:00 am and 4:00 am.

R1's Progress Notes dated 6/15/23 documents R1 was found face down on the floor, behind the door, by CNA. R1 was confused prior to the fall and now was not able to tell nurse his name. R1 was noted to have blood coming from R1's head and a large hematoma to the right eye and

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S9999	Continued From page 3 forehead. 911 was called and R1 was sent to the Hospital. R1's Hospital History and Physical dated 6/15/23 documents R1 presented to the ED (Emergency Department) following an unwitnessed ground level fall. According to the chart review, upon EMS (Emergency Medical Services) arrival, R1 was noted to be with decreased LOC (Level of Consciousness) and noted with obvious head injury near R1's right eye. Additionally, in route to the ED, R1 was noted to be hypoxic for which R1 was placed on a non-rebreather mask with 100% FiO2 (Fraction of Inspired Oxygen). While in the ED, R1's LOC continued to decline with a Glasgow Coma Scale rating of 1 meaning "no response." R1's preliminary CT (Computed Tomography) imaging of the brain showed concerns for intracranial bleed. R1's CT scan dated 6/15/23 documents R1 has an Acute 1.6 cm (centimeter) Intraparenchymal Hemorrhage involving the left parietal paraventricular white matter and extending to the left basal ganglia with a large amount of blood spilling into the body of the left lateral ventricle as well as body of right lateral ventricle. R1 also has an extensive right periorbital hematoma. R1's Hospital Discharge Summary dated 6/15/23 by V8 Physician documents - R1 was admitted to the hospital with an extensive ICH (Intracranial Hemorrhage) after sustaining a ground level fall while on Eliquis. R1's prognosis was poor and R1 was not expected to survive. R1 expired later in the day. Cause of Death: Intracranial Hemorrhage with anticoagulant use for AFib (Atrial Fibrillation). On 6/27/23 at 11:01, V3 Agency LPN (Licensed	S9999		

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S9999	Continued From page 4	S9999		

Practical Nurse) stated R1 was confused but pleasant at time of R1's admission. R1's family was very concerned about R1's decline and R1's falling. Prior to admission, R1 resided at home with V11 and V11 was R1's primary caregiver. V11 requested R1 be toileted at 1 am and 4 am because that is what R1 was used to because that is when V11 got R1 up to toilet when at home. V3 stated V3 passed that information on to the oncoming nurse and also charted the information because "even though (R1) was not cognitively with it, his body would still wake up and he would want to toilet because that is what he was used to."

On 6/27/23 at 11:13 am, V11 stated V11 had requested R1 be toileted at 1 am and 4 am due to that being the schedule that R1 was used to at home for the past couple of weeks. V11 also stated R1 ambulated very slowly and needed assistance with stabilization due to R1's unsteady balance.

On 6/27/23 at 11:25 am, V10 CNA stated V10 had assisted V12 LPN with toileting R1 around 9 or 10 pm using a gait belt and walker due to R1 being unsteady. V10 then stated the next time V10 had any interaction with R1 was at midnight but that R1 was asleep so R1 was not toileted at that time, then about 1:15 am, V5 CNA yelled out for help so V10 responded and saw R1 lying face down on the floor, behind the door, bleeding from R1's head, so V10 went to get the nurse. V10 stated V10 was not given any information on R1, including when or how R1 toileted.

On 6/27/23 at 11:42 am, V12 Agency LPN stated R1 was very confused upon admission to the facility, a very high fall risk because R1 really didn't understand R1's own mobility limitations

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S9999	Continued From page 5 and kept trying to get up independently and kept losing R1's balance. V12 stated V12 and V10 had toileted R1 before 10:00 pm, then put R1 to bed for the night. V12 stated V12 went to another unit at 11:00 pm but later in the night, came back to the unit to assist V4 Agency LPN, due to R1 falling. V12 stated prior to R1's family leaving for the night, V11 asked how often we (facility staff) check on residents and V12 told V11 that residents are checked on every 2 hours and toileted at those times. V11 was asking due to R1's confusion and trying to get up so V12 told V11 due to R1's confusion, V12 would have the CNA's check on R1 every hour to see if R1 needed anything and V11 was okay with that. V12 stated that V3, who admitted R1, never reported to V12 that R1 needed to get up at 1:00 am and 4:00 am. On 6/27/23 at 11:55 am, V4 Agency LPN stated V4 was not given report by V3 or V12 upon arriving for V4's night shift, therefore was not given any information regarding R1's fall risk or specific needs for toileting during the night. V4 stated an unidentified nurse did tell V4 that R1 had a lot of confusion, decreased safety awareness, and that R1 required one assist for toileting. V4 then stated around 1:15 am on 6/15/23, R1 fell. V4 explained staff had to log roll R1 to get R1 moved to see R1's injuries, due to being facedown behind the door. V4 stated R1 had a large hematoma to R1's forehead and eye. V4 explained R1 had a history with bleeding, had blood coming from the hematoma and was not responding at all so, R1 was sent to the hospital. V4 stated R1 was rounded on every two hours. V4 stated staff didn't tell V4 that R1 needed checked on more frequently. (A)	S9999		

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