(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,			SURVEY LETED		
				A. BUILDING:		С	
		IL6005250		B. WING	03/13/2024		
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LA SALL	E COUNTY NURSING	HOME	1380 NOF OTTAWA,	RTH 27TH RC IL 61350	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC ' MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
S 000	Initial Comments			S 000			
	Complaint Investiga	ation: 2421682/IL17	70393				
S9999	Final Observations			S9999			
	Statement of Licens 300.610a) 300.1210a) 300.1210b)5) 300.1210d)3)6) Section 300.610 Rea) The facility shall procedures governifacility. The written be formulated by a Committee consisti administrator, the amedical advisory conformation of nursing and othe policies shall composite the facility and shall by this committee, and dated minutes	esident Care Policie have written policieng all services provention policies and procentions and representation of at least the divisory physician committee, and representations in the fact y with the Act and the shall be followed in the reviewed at lead documented by writers.	es and vided by the dures shall cy or the esentatives cility. The this Part. In operating ast annually				
	Section 300.1210 C Nursing and Person a) Comprehensive with the participation resident's guardian applicable, must decomprehensive car includes measurab meet the resident's and psychosocial noresident's comprehensive	nal Care Resident Care Plar n of the resident ar or representative, velop and impleme e plan for each res e objectives and tin medical, nursing, a eeds that are ident	n. A facility, and the as ent a ident that metables to and mental ified in the				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/22/24 **Electronically Signed**

TITLE

STATE FORM 6899 If continuation sheet 1 of 5 GOUW11

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6005250	B. WING			C 13/2024
LA SALLE COUNTY NURSING HOME 1380 NOR			DDRESS, CITY, S RTH 27TH RO A, IL 61350			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	allow the resident to practicable level of provide for discharg restrictive setting by needs. The assess the active participat resident's guardian applicable. (Section b) The facility shall and services to attapracticable physica well-being of the reeach resident's complan. Adequate and care and personal or resident to meet the care needs of the resident and personal or resident to meet the care needs of the resident and personal or resident to meet the care needs of the resident and personal or resident to meet the care needs of the resident and personal or resident to meet the care needs of the resident and personal or resident to meet the care needs of the resident and personal or resident to meet the care needs of the resident and personal or resident to meet the care needs of the resident and personal or resident to meet the care needs of the resident and personal or resident to meet the care needs of the resident and personal or resident to meet the care needs of the resident and personal or resident to meet the care needs of the resident and personal or resident to meet the care needs of the resident and personal or resident to meet the care needs of the resident and personal or resident to meet the care needs of the resident and personal or re	o attain or maintain the highes independent functioning, and ge planning to the least ased on the resident's care sment shall be developed with tion of the resident and the or representative, as a 3-202.2a of the Act) I provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with apprehensive resident care I properly supervised nursing care shall be provided to each the total nursing and personal tesident. Dersonnel shall assist and as with ambulation and safe as often as necessary in an aretain or maintain their highest seed and safe as often as necessary in an aretain or maintain their highest and the safe as often as necessary in an aretain or maintain their highest as a second as a second and safe as often as necessary in an aretain or maintain their highest as a second and a safe as a second and a safe as a second and a safe as often as necessary in an aretain or maintain their highest and a safe as a second and a safe as a safe as a safe as a safe a safe a safe and a safe as a safe a sa				
	care shall include, a and shall be practic seven-day-a-week 3) Objective of resident's condition emotional changes determining care re					
	made by nursing st resident's medical r 6) All necessa to assure that the r as free of accident nursing personnels	aff and recorded in the	3			

Illinois Department of Public Health

STATE FORM 6899 GOUW11 If continuation sheet 2 of 5

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION		SURVEY PLETED	
		IL6005250	B. WING			C 13/2024
	PROVIDER OR SUPPLIER	HOME 1380 NO	DDRESS, CITY, S RTH 27TH RC , IL 61350	STATE, ZIP CODE DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
S9999	Continued From pa		S9999			
	This REQUIREMEN	NT is not met as evidenced by:				
	failed to implement at risk for falls for o reviewed for falls in resulted in R1 expe	and record review the facility fall interventions for a resident ne of three residents (R1) a sample of three. This failure riencing an unwitnessed fall, ining a left hip fracture epair.				
	Findings include:					
		l Risk Assessment, dated hat R1 is at risk for falls.				
	documents that R1 assist for locomotic documents that R1	Plan, dated 2/2/24, requires one-person physical on on the unit. This form is cognitively impaired. R1's does not have fall or safety ce.				
		ehabilitation Evaluation, dated that R1 requires extensive n for transfers.				
	documents that R1 was assisted to bed	es, dated 2/11/24 at 6:45am, was awake at 4:15am. R1 d, but got out of bed. R1 was om and fluids were offered, wil				
	that at 8:30pm, V4	es, dated 2/12/24, documents (Licensed Practical 1 by her side, due to R1				

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Illinois Department of Public Health

IL6005250 B. WING	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 NORTH 27TH ROAD OTTAWA, IL. 61350 (XA) ID PREPEIX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 3 repeatedly trying to walk. R1 was given a stuffed animal to hold. V4 documented that she came out of a room after giving a medication and heard R1 say AHI R1 was rubbing her left knee. V4 documented that R1's knees were checked for injuries, but none were noted. R1 was asked if she could move her legs, which she did. R1 was assisted up to her wheelchair. R1 progress notes document that R1 was rubbing above her knees. V6 (R1's Primary Care Physician) gave orders for hip and knee x-rays. R1's Progress Notes, dated 2/13/24 at 12:45am, documents that R1 was crying out with facial grimacing and grabbing her left leg and hip area. R1 was sent to the emergency room for suspected hip fracture. At 41'41am, V3 (Registered Nurse) documented that R1 was being admitted to the hospital for a left hip fracture. V9's (Certified Nursing Assistant) signed Witness Interview Form, dated 2/12/24, documents that Resident (R1) frequently stands, self-transfers, walks around unsupervised. This form documents that R1 was one on one with the nurse while passing medications. On 3/13/24 at 10:30am, V7 (Registered Nurse) stated that R1's								
A SALLE COUNTY NURSING HOME			IL6005250	B. WING		03/1	3/2024	
CALLE COUNTY NURSING HOME	NAME OF	PROVIDER OR SUPPLIER						
CM4 ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY YULL REGULATORY OR LSG IDENTIFY/NG INFORMATION) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY YULL REGULATORY OR LSG IDENTIFY/NG INFORMATION) PREFIX (EACH DEFICIENCY) COMPLETE DATE DATE	LA SALL	E COUNTY NURSING	HOME		DAD			
repeatedly trying to walk. R1 was given a stuffed animal to hold. V4 documented that she came out of a room after giving a medication and heard R1 say AH! R1 was rubbing her left knee. V4 documented that R1's knees were checked for injuries, but none were noted. R1 was asked if she could move her legs, which she did. R1 was assisted up to her wheelchair. R1 progress notes document that R1 was rubbing above her knees. V6 (R1's Primary Care Physician) gave orders for hip and knee x-rays. R1's Progress Notes, dated 2/13/24 at 12:45am, documents that R1 was crying out with facial grimacing and grabbing her left leg and hip area. R1 was sent to the emergency room for suspected hijp fracture. At 4:14am, V3 (Registered Nurse) documented that R1 was being admitted to the hospital for a left hip fracture. V9's (Certified Nursing Assistant) signed Witness Interview Form, dated 2/12/24, documents that Resident (R1) frequently stands, self-transfers, walks around unsupervised. This form documents that R1 was one on one with the nurse while passing medications. On 3/13/24 at 10:30am, V7 (Registered Nurse/Minimum Data Set Nurse) stated that R1's	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETE	
base line care plan did not have fall interventions put into place. V7 verified that R1 should have had a completed care plan at the time of her fall. On 3/13/24 at 2:20pm, V1 (Administrator) stated that R1 had a history of falls prior to admission to the facility. V1 stated that the facility does not have the staff to do one on one care. On 3/13/24 at 2:50pm, V4 (LPN) stated that R1	\$9999	repeatedly trying to animal to hold. V4 of a room after givin say AH! R1 was rut documented that R injuries, but none we she could move her assisted up to her very document that R1 v76 (R1's Primary C hip and knee x-rays R1's Progress Noted documents that R1 grimacing and grab R1 was sent to the suspected hip fract (Registered Nurse) being admitted to the fracture. V9's (Certified Nurse Interview Form, dat Resident (R1) frequently walks around unsuf documents that R1 nurse while passing On 3/13/24 at 10:30 Nurse/Minimum Dabase line care plan put into place. V7 version had a completed care that R1 had a historic the facility. V1 states have the staff to do had a completed care that R1 had a historic the facility. V1 states have the staff to do had a completed care that R1 had a historic the facility. V1 states have the staff to do had a completed care that R1 had a historic the facility. V1 states have the staff to do had a completed care that R1 had a historic that R1 had a historic the facility. V1 states have the staff to do had a completed care that R1 had a historic that R1 had a h	walk. R1 was given a stuffed documented that she came out ng a medication and heard R1 obing her left knee. V4 1's knees were checked for were noted. R1 was asked if r legs, which she did. R1 was wheelchair. R1 progress notes was rubbing above her knees. are Physician) gave orders for s. es, dated 2/13/24 at 12:45am, was crying out with facial bing her left leg and hip area. emergency room for ure. At 4:14am, V3 documented that R1 was ne hospital for a left hip sing Assistant) signed Witness and 2/12/24, documents that uently stands, self-transfers, pervised. This form was one on one with the grand matches are plan at the time of her fall. Dam, V7 (Registered that R1's did not have fall interventions erified that R1 should have are plan at the time of her fall. Dom, V1 (Administrator) stated that the facility does not one on one care.	S9999				

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.			,
		IL6005250	B. WING		1	3/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LA SALI	E COUNTY NURSING	HOME 1380 NOR OTTAWA,	TH 27TH RO IL 61350	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	was anxious and ke stated that the staff so she took R1 with V4 stated that she medicine then hear to check on R1 and stated that R1 was show signs or symp R1 had adverse be R1 was out of sight stated that R1 did returning from the holiowing from the holiowing information concerns or problem assessment of the The facility's Falls a modified 10/31/23, Assessment 2.0 For as possible and propagation of the fall. This form also care plan is reviewed Approaches will be	ept trying to stand up. V4 could not get their jobs done, her during medication pass. entered a room to give d a "Ah". V4 stated she went I she was on the floor. V4 rubbing her knees but did not otoms of pain. V4 verified that haviors often. V4 verified that for only a minute and fell. V4 not get out of bed after hospital. Plans policy, reviewed hts that the resident care plan he of admission. This form care plan will include the havior but not limited: needs, ms identified during initial resident. And Incident Reporting policy, documents that a Fall risk form is to be completed as soon acticable, within 24-48 hours and a resident has sustained a documents that the resident's ed and revised as indicated. implemented for ongoing entions will be done on a	\$9999			

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