STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012579	A. BUILDING: _____ B. WING _____	C 03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK SENIOR LIVING	180 WEST IMBODEN DECATUR, IL 62521

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of March 9, 2024 IL171046	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 d)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. 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 are not met as evidenced by: Based on interview and record review, the facility failed to provide safe and effective supervision of	S9999		

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S9999	Continued From page 1	S9999		

R1 during incontinence care to prevent a traumatic fall. This failure resulted in R1 falling from R1's bed, striking R1's head on an adjacent nightstand, and landing on the floor resulting in a collarbone fracture and scalp laceration requiring emergency medical treatment at the hospital. R1 is one of three residents reviewed for accidents in the sample of three.

Findings include:

R1's medical diagnosis list (3/22/2024) documents R1's diagnoses include: Muscle Weakness, Spinal Stenosis (narrowing), Cerebral Infarction (partial brain tissue death due to disruption in blood flow), Lumbago (low back pain), Osteoarthritis, Central Pain Syndrome, Presence of Artificial Hip Joint, Dementia, Depression, and Anxiety Disorder.

R1's quarterly assessment (12/8/2023) documents R1 has both upper and lower extremity impairment limiting R1's range of motion, is frequently incontinent of bowel and bladder, and requires the assistance of two or more staff for toileting hygiene and to roll left and right while in bed.

R1's Fall Risk assessment, dated 1/21/2024, documents R1 has a history of falls and is at high risk for experiencing falls.

R1's 7 Day Look Back Charting (3/8/2024) documents R1 has moderately impaired cognition and requires the assistance of two or more staff for turning and repositioning in bed.

The facility incident report (3/9/2024) documents V3 (Certified Nurse Aide) provided incontinence care to R1 on 3/9/2024 while R1 was in bed. The

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same report documents V3 had rolled R1 to R1's side to provide care, and when V3 turned to reach for an incontinence brief, R1 fell out of bed onto the floor and was sent to the hospital emergency department for evaluation and treatment. The report does not document any other staff were present during V3's care of R1 on 3/9/2024.

The hospital emergency department report (3/9/2024) documents facility staff reported R1 hit R1's head on a nightstand during a fall from bed on 3/9/2024. The same record documents R1 sustained a clavicle (collarbone) fracture and scalp laceration requiring sutures as a result of the fall. The report documents R1 complained of head pain while in the emergency department and received intravenous narcotic pain medication.

The facility incident investigation (3/9/2024-3/11/2024) documents a signed witness statement from V3 (Certified Nurse Aide) describing R1's fall on 3/9/2024. V3's statement documents R1 was in bed when V3 changed R1's clothing and removed R1's incontinence brief and positioned R1 on R1's right side to apply a new brief on R1, with V3 holding R1 in position with V3's right hand. The same record documents V3 noticed the new brief had fallen to the floor, and when V3 kneeled down to retrieve the brief, R1 rolled away from V3 (and fell out of bed onto the floor). The statement documents R1 complained of shoulder pain and an ambulance was called to transport R1 to the hospital.

The investigation interview of V3 (3/9/2024) documents V3 reported providing incontinent care to R1 on 3/9/2024 and had placed R1 on R1's side while R1 used a bed side rail to hold R1's

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self in the side position while receiving care from V3. The interview documents V3 reported R1's new incontinence brief had fallen onto the floor, and when V3 bent down to retrieve the brief, R1 rolled away from V3 and fell to the floor.

V2's (Director of Nursing) Staff Statement (3/9/2024) documents V2 observed R1 on the floor between R1's bed and wall after the fall, and when R1 was moved, blood was noted on the floor and an open area was found on the back of R1's head. The Statement documents R1 complained of head and left shoulder pain to V2.

The facility In-Service attendance roster (3/9/2024) documents facility nursing staff received training to use two staff for bed mobility for R1.

The facility In-Service Training Report (3/9/2024) documents V1 (Administrator) in-serviced V3 (Certified Nurse Aide) on 3/10/2024 about resident safety. The record documents: "When supplies are/or have fallen to floor they are not to be reused on resident due to sanitary guidelines. Staff member retrained to make sure resident in safe position before getting supplies."

On 3/22/2024 at 2:00PM, V3 reported providing incontinence care to R1 on 3/9/2024, and R1 rolled forward and fell out of bed when V3 went to place a new incontinence brief beneath R1. V3 did not report dropping R1's new brief to the ground and bending down to retrieve the brief when R1 fell from the bed as V3 had reported in V3's written statement in the facility investigation of R1's fall. V3 reported no other staff were present on 3/9/2024 when R1 fell from bed and stated, "I'm pretty sure (R1's) head hit on (R1's) bedside table (when R1 fell to the floor)." V3

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S9999	Continued From page 4 reported R1 complained of shoulder pain after the fall. V3 denied being aware of R1 having any history of falling from bed and denied R1 has any behaviors, resists care from facility staff, or has any other issues increasing R3's risk of falls when staff provide incontinence care to R1. V3 reported R1 had a grab bar in place on R1's bed at the time of the fall. On 3/26/2024 at 11:15AM, V4 (Licensed Practical Nurse) reported all resident incontinence care "is supposed to be" completed by two staff members. On 3/26/2024 at 3:15PM, V7 (Certified Nurse Aide) reported frequently providing care to R1 since R1's admission to the facility. V7 denied R1 ever had any bed side rails or grab bars of any type during R1's stay in the facility. V7 reported R1 has never been able to grasp a grab bar or side rail and R1 is unable to roll herself in bed or independently complete bed mobility. (B)	S9999		