STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	C 05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

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S 000	Initial Comments Facility Reported Incident of 5/8/24; IL173011	S 000		
S9999	Final Observations Statement of Licnesure Violations 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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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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.

This requirement was not met as evidence by:

Based on interview and record review the facility failed to ensure fall prevention interventions were in place for a resident with a history of falls. This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3. This failure resulted in R1 falling and fracturing her left hip.

The findings include:

R1's Face Sheet (Admission Record) showed an admission date of 12/13/23 with diagnoses to include dementia, depression, and left femur fracture (admitting diagnosis).

R1's 3/19/24 Significant Change Assessment Minimum Data Set (MDS) showed severe cognitive impairment with a brief interview for mental status (BIMS) score of 6 out of 15. The MDS showed she was dependent upon staff for transfers from bed to chair transfers and she had not walked. The MDS showed she used a

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wheelchair for mobility and bed/chair alarms were used daily.

R1's Progress Notes showed the following fall events: On 4/29/24 at 1:16 PM, "...[R1] was laying towards her right side in front of her w/c (wheelchair)..." On 4/26/24 at 4:42 PM, "CNA (Certified Nursing Assistant) yelled out for help for fall resident observed on the floor sitting on the floor..." On 3/29/24 at 12:25 PM, "Resident in nursing station after eating lunch with husband. She attempted to stand up, w/c moved back and she slid off to the floor..." On 1/17/24 at 2:00 PM, "Reported to nurse that patient was observed sitting on the floor in another resident's bathroom..." On 1/15/24 at 4:00 AM, "Observed resident sitting on the floor in an upright position..." On 1/1/24 at 3:20 AM, "...observed resident sitting on floor next to floor mat with legs straight out..." On 12/18/23 at 1:20 PM, "Resident has been self-transferring and standing up frequently, doesn't follow directions, propelling self on w/c... resident observed on the floor..."

R1's 5/8/24 Event Note from 5:30 AM showed, "Resident observed sitting on floor with her back against another resident w/c (wheelchair) while other resident sitting in w/c. Resident stated that she didn't hit her head. No pain noted. Resident stated that she was just getting up. House supervisor notified, resident assessed, ROM wnl (Range of Motion within normal limits) ...." The note showed vital signs and a neurological assessment was completed. The not continued, "Resident c/o (complains of) discomfort to left hip post fall..." The note showed the provider was notified and an Xray was ordered.

R1's 5/9/24 Left Hip Xray showed an "Acute (sudden onset) acetabular and left inferior pubic

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ramus fractures (fractures of the pubic bone where the hip connects to the pubic bone.) ..."

The facility's staff schedule showed V6 CNA and V4 Licensed Practical Nurse were working the third shift on 5/7/24 for R1's unit.

On 5/14/24 at 11:05 AM, V6 stated he was doing rounds early morning on 5/8/24. V6 stated R1 was awake and sitting at the edge of the bed so he toileted her and got her ready for the day. V6 said, "...once she's up she likes to stay up..." V6 said he transferred R1 to her wheelchair and brought her out the nurses' station. V6 said he left R1 at the nurses' station and went down the hall to speak with V4. V6 said two to three minutes later he heard a resident yelling out at the nurses' station, so he investigated. V6 said R1 was sitting on the floor with her back resting on another resident's wheelchair. V6 said, "There was no alarm in her wheelchair at that time. I didn't realize she was supposed to have one...Supposedly she had a chair alarm, and it was left in the recliner..." V6 clarified the recliner was at the nurses' station and the night prior and the staff member who transferred R1 out of that recliner did not place the chair alarm in the wheelchair. V6 said, after the fall, R1 was transferred to the wheelchair and approximately 30 minutes later she began to complain of "pain" to the left hip. V6 said, "The purpose of the chair alarm is to alert the staff that someone is trying to get up. It is true, a chair alarm might not prevent a fall. It might prevent a fall if we can get there quick enough." V6 stated the supervisor who responded to the fall was V11 RN.

On 5/14/24 at 12:58 PM, V4 stated she was R1's third shift nurse beginning on 5/7/24. V4 stated, the morning of 5/8/24, she heard another resident

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yelling at the nurses' station and R1 was found sitting on the floor with her back resting against another resident's wheelchair. V4 stated R1 did not have a chair alarm in her wheelchair; it was in the recliner. V4 said, "It was supposed to be in the wheelchair. When the CNA got her up, I don't think he realized it wasn't there. The purpose of the chair alarm is to alert us the resident is getting off the pad or let us know they are getting up. The chair alarm gives us a heads up that someone is trying to move just so we know if they are moving."

On 5/14/24 at 11:30 AM, V11 Part-time House Supervisor stated she responded to R1's fall. V11 said, while she was filling out the fall report, "...I got to the alarm part, and I asked CNA was the chair alarm sounding? Because I didn't understand what took so long for them to respond if they were responding to a resident screaming instead of the alarm and the CNA said the alarm was in the recliner. I asked was it was supposed to be in the wheelchair, and they said yes. By the time I looked at the wheelchair, they had put the alarm in the wheelchair. The purpose of the chair alarm is to let us know when someone is starting to get out of the chair. It should alarm as soon as their butt gets off that pad so we can start moving toward the resident right away. Chair alarms don't always prevent a fall, but they can give us a couple of extra seconds to respond to a resident to get them to sit back down before they fall. We generally have fewer staff on third shift, so I would say those alarms are even more important on third shift than other shifts because, if they only have two CNAs for four halls, they can't be everywhere, so it helps them to respond when a resident is getting up."

On 5/14/24 at 2:06 PM, V2 Director of Nursing

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stated the purpose of chair alarms is to "reduce the risk of falls to the resident. They help by giving the staff a heads up that the person is trying to get up and they can attempt to intervene. [R1] should have had a chair alarm that morning when she fell..."

On 5/14/24 at 1:14 PM, V12 Nurse Practitioner stated she was on-call when R1's Xray results became available. V12 said she does not know R1's history; however, "the fractures she sustained are fractures I see after someone has a fall."

On 5/14/24 at 1:20 PM, V13 Medical Director/R1's provider stated the fractures R1 sustained are "...typical and most common after a fall..." V13 stated R1's fractures were a result of the fall and most likely and undiagnosed condition of osteoporosis (weakening of the bones).

R1's Care Plan showed, "[R1] is at risk for fall r/t (related to): confusion, weakness, incontinence, Poor communication & comprehension, Impaired physical mobility, unaware of safety needs & her own risk factor, hx of fall, behavior of self-transferring without assist, aggressive behaviors towards the staff when redirected, impulsive behavior..." The care plan showed the following intervention, "Chair alarm when up in chair/wheelchair. Date initiated 12/15/23."

R1's April and May 2024 Medication Administration Record showed pain assessments were completed every shift (every 8 hours). Except for one pain assessment in April 2024, R1 did not have documented pain during these shift assessments until after her fall on 5/8/24.

(A)

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