| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| BRIA OF GODFREY | 1623 29 WEST DELMAR GODFREY, IL 62035 |

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| S 000 | Initial Comments<br><br>Complaint Investigation 2444511/IL174117 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610 a)<br>300.690 a)<br>300.1210 b)<br>300.1210 d)3)<br>300.1210 d)6)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.690 Incidents and Accidents<br>a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. | S9999 | | |

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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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 assure appropriate fall interventions were in place and supervise 1 of 4 (R3) residents reviewed for falls and safety in the sample of 4. This failure resulted in R28 sustaining multiple falls, bruising of varies stages of healing, and a laceration to R3's head.

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Finding includes:

1. R3's Admission Record, not dated, documents R3's Admission date 5/30/2024. It also documents Hemiplegia and Hemiparesis following Cerebral Infarction Affecting left non-dominant side, Type 1 Diabetes Mellitus with other specified complication, Dysphagia following cerebral infarction, Cerebral Infarction, unspecified, Chronic Obstructive Pulmonary Disease, unspecified, Difficulty in walking, not elsewhere classified, weakness, unsteadiness on feet, Displaced Intertrochanteric Fracture of Right femur, Chronic pain syndrome, Unspecified History of falling, and polyneuropathy, unspecified, listed as diagnoses.

R3's Baseline Care Plan, dated 5/30/2024, documents R3 is at high risk for falls. It continues, "Interventions: A. Call light within reach B. Provide clutter-free environment C. Encourage use of assistive device D. Provide proper, well-maintained footwear." It also documents, "Fracture 1. Focus: A. Resident (res) has limited mobility related to fracture 2. GOAL: A. Resident's mobility status will return to pre-fracture status 3. INTERVENTIONS: A. Assist with repositioning as needed B. Do not lay resident on affected side C. Do not allow resident to cross legs if he/she has a hip fracture 4.Comments: right hip fracture, recent surgical repair."

R3's Fall Risk Assessment, dated 5/30/2024, documents R3 has decreased mobility (stiffness, limitation in ROM (range of motion), contractures, amputation). R3 has Predisposing HTN (hypertension), CVA (cerebral vascular accident), Parkinson's, Hypotension, Seizure, Osteoporosis. R3 has Impaired memory or judgement, History of falls in the past 1-6 months, S/P Fall and/or

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Fracture in past 6 months and Drugs that have a diuretic effect or increase GI (gastro instestinal) motility. Drugs that affect the thought process (i.e. sedatives, hypnotics, narcotics, analgesics). Drugs that create a hypotensive effect (newly ordered or dosage adjustment).

R3's Nurses Notes, dated 5/30/2024 2:35 PM, documents, "Note Text: Patient admitted (Facility) from (Regional Hospital) transported by EMS (emergency medical service). Patient arrived by stretcher and patient is alert and oriented times three. Patient is able to make her needs known. Patient is a one assist while transferring and requires a wheelchair. Patient had no complaints of pain and abdomen was non distended. Bowel sounds were heard in all four quadrants. Patient is a regular diet with regular liquids. Patient last BM (bowel movement) was 5/30/24. No complaints of SOB (shortness of breath) and no oxygen required. Lungs clear. Patient is a smoker and wanted to smoke while getting off the stretcher, but Nurse educated patient that she had to be evaluated by therapy first. Skin is warm and dry, no bruises or injuries. Nurse has educated patient on how to use call light and bed remote. Patient is now in bedroom with hydration available and call light accessible."

R3's Progress notes, dated 5/30/2024 7:19 PM, documents, "Nurses Notes Note Text: Res (resident) fell in room and hit head. Res alert no visible injuries. Blood pressure is 161/88, pulse 89 resp 20 non labored blood sugar 277. Res (resident ) c/o (complain of) right hip pain r/t (related to) post op (operation). Res transferred via ambulance to (local hospital) eval and treatment. Attempted to notify POA (power of attorney) ,wrong number. Attempted to notify POA (Power of Attorney) #2 no answer. Report called

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| S9999 | Continued From page 4<br>to (local hospital)."<br><br>R3's Incident report, dated 5/30/24 10:49 PM, documents R3 was found on back in her room on floor no visible injuries. Oriented to person, place, time and situation. Predisposing Factors: gait imbalance, impaired memory , admitted within last 72 hours, during transfer. It also documents that R3 had recently fracture of right femur, resident newly admitted to facility. No root cause analysis was identified.<br><br>R3's Physician Order Sheet, dated 6/1/24-6/30/24, documents Resident is placed on enhanced supervision. Every shift for safety.<br><br>R3's Care Plan, dated 6/4/2024, documents, "FALL: (R3) is at high risk for falls r/t (related to) having a history of repeated falls, diagnoses of CVA (stroke), right hemiparesis, schizoaffective disorder, bipolar disorder, psychosis, and anemia. She takes blood thinners, antidepressants, and seizure medications. She has poor short-term memory and poor safety awareness." It continues, "5/30/24-Was sent to (Local Hospital emergency room) for evaluation due to use of blood thinners. 6/2/24-Placed on enhanced supervision with 15 minute checks. 6/4/24-Residents room moved closer to the nurse's station upon return from hospital. 6/4/24-send to (local hospital emergency room) for evaluation due to use of a blood thinner. FSBS (fingerstick blood sugars), Vitals, Head to toe assessment with neuro checks and Resident not moved, and staff remained by her side until EMTs (emergency technician) arrived to transport to hospital. Educate resident on the importance of complying with safety measures. Document residents understanding of education and instances of noncompliance. Evaluate multiple | S9999 | | |

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falls to determine commonalities or patterns."

R3's Progress Notes, dated 6/4/2024 at 7:38 PM, documents, "Nurses Notes, Note Text: During shift change resident had a fall. Went down to assess the resident she states she was trying to get from her wheelchair to the bathroom and she fell. per assessing the resident, she did have a laceration to the back of her head and the right side of her leg. Resident was sent to (local Hospital) a x-ray and ct (computed tomography) scan everything was negative. Resident was sent back with no new order besides pain, Which was set to NP (nurse practitioner) and pharmacy."

R3's Progress Notes, dated 6/6/2024 at 7:30 PM, documents, "Nurses Notes, Note Text: visitor came to desk and said he seen a resident on the floor as he was walking past. this nurse and CNA (Certified Nursing Assistant) went to room and noted resident inside door of her room. resident in w/c, w/c laying on its side with resident in it. her head resting against the bathroom door. Resident able to move all extremities and denied any injury. this nurse and CNA assisted resident to standing position and back into upright w/c (wheelchair). (V10) N.P. (Nurse Practitioner) and DON (Director of Nursing) notified. (local Hospital) ambulance notified of need for transport. report called to (local hospital emergency room) nurse for eval post fall. resident left at this time per (local hospital) ambulance. resident alert and oriented x2. skin w/d (warm and dry). resp nonlabored on room air."

R3's Incident report, dated 6/6/2024 at 7:00pm, documents the nurse was alerted by visitor that the resident on floor. Upon the nurse and CNA entering room noted resident on floor inside door of room. Resident in wheelchair laying on side

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with resident in it. head resting against bathroom door. Resident able to move all extremities and denied any injury. Resident stated that she was trying to go in the bathroom. It also documents that R3 is confused/forgetful. Oriented to person and place. Redisposing factors noncompliant with safety guidance, gait imbalance, impaired memory. No root cause analysis provided.

On 6/11/2024 4:00 PM, requested R3's Enhanced Supervision Monitoring Tool every 15minutes documentation. As of 6/18/2024 at 3:00 PM, the facility has not provided the Enhanced Supervision 15-minute documentation for 6/4/2024.

On 6/11/2024 at 4:20 PM, observed V7, CNA, and V11, RN, assist R3 with applying the lift pad. R3's pant legs were raised revealing large discolorations in various stages of healing ranging from yellow, green, blue, purple, and black in color.

On 6/12/2024, a review of R3's Electronic Health Record revealed there was not a Fall Risk Assessment performed on 6/4/2024.

On 6/12/2024 at 11:00 AM, requested R3's fall investigations. The facility was unable to provide R3's investigation for 6/4/2024. At 4:40 PM, V2, Director of Nursing, provided R3's incident report for 6/4/2024 incident that was completed 6/12/2024. No root cause analysis identified.

On 6/12/2024 at 3:00 PM, V2, Director of Nursing, stated she completed the incident report for 6/4/2024, today, (6/12/2024), and used the nurses note in the computer.

As of 6/12/2024 at 4:00 PM, R3's medical record

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does not document bruising to R3's legs, and arms.

On 6/11/2024 at 4:50 PM, R3 stated she has fallen at the facility. R3 stated she fell and broke her leg prior to being at the facility. R3 stated she was trying to go to the bathroom. R3 stated she likes to do things herself. R3 stated it takes so long for them to come and help. R3 stated she doesn't want to go on herself. R3 stated she pulls the cord, but they never come.

On 6/13/2024 at approximately 1:30 PM, V13, Wound Nurse/LPN, stated she was at the facility when R3 fell on 6/4/2024. V13 stated she was notified that R3 fell. V13 stated she went to the room and saw R3 lying on floor with blood coming from her head. V13 stated the nurse was an agency nurse. V13 stated because R3 was bleeding, R3 was sent to the hospital. V13 stated R3 is at high risk for falls. V13 stated R3 requires increased supervision and was placed on enhanced supervision because R3 was trying to transfer self. V13 stated R3 is alert and able to verbalize her needs and have an alert conversation. V13 stated she was aware of R3's bruises and scratches. R3 stated on the day of the fall, it was not clear as to where the blood was coming from, and R3 was sent to the hospital. V13 stated ]she completed the documentation in the computer yesterday (6/12/2024).

On 6/12/2024 at 3:10 PM, V4, Registered Nurse (RN), stated she has cared for R3. V4 stated R3 requires supervision and should not be in her room unattended, unless in bed. V4 stated R3 has had multiple falls, a fracture and multiple comorbidities that would put her at risk for falls. V4 stated R3 makes multiple attempts to transfer herself. V4 stated they try to keep R3 out front by

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the nurse's station. V4 stated R3 can move the chair and move around in the facility. V4 stated she was the nurse on 6/6/24 when R3 fell. V4 stated R3 was in her room in her wheelchair prior to the fall. V4 stated a visitor informed her R3 was on the floor. V4 stated she went to the room and R3 was lying on the floor inside her wheelchair, with her head against the bathroom. V4 stated the chair was folded on its side with R3 inside. V4 stated she was worried R3 would have hit her head because she may have not been able to brace herself.

On 6/12/2024 at 3:15 PM V5, Licensed Practical Nurse (LPN), stated she is familiar with R3. V5 stated R3 is at high risk for falls. V5 stated R3 has had multiple falls since being at the facility. V5 stated she was present for 2 of R3's falls. V5 stated R3 was in her room alone at time of falls. V5 stated R3 was responding to toileting. V5 stated they try to keep R3 out of her room and near the nurse's station or in activities because R3 will try to transfer herself. V5 stated R3 is alert and able to express herself. V5 stated R3 has not had any injuries. V5 stated R3 was placed on 15-minute checks.

The facility's Fall Prevention and Management policy, dated 9/2023, documents, "The facility Is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the residents existing plan of care shall be evaluated and modified as needed. Upon admission a fall risk evaluation will be completed on admission, readmission and quarterly, significant change and

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| S9999 | Continued From page 9<br>after each fall. Residents at risk for fall will have fall risk identified on the interim plan of care ant the ISP with interventions implemented to minimize fall risk. the facility guidelines following a fall incident are listed 1. Evaluate for injury and notify physician and emergency contact. 2. Complete a fall incident report in PCC risk management portal. 3. a fall risk evaluation is completed by the nurse. A score of 10 or greater indicates the resident is at high risk for falls; a score of less that 10 indicates at risk for falls. 4. Care plan to be updated with new intervention based on root cause analysis after each fall occurrence. 5. Complete follow up monitoring form every shift for 72 hours."<br><br>(B) | S9999 | | |