| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | IL6000400 | A. BUILDING: _____ B. WING _____ | 04/19/2024 |

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| S 000 | Initial Comments<br><br>Annual Licensure and Certification Survey | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.1210a)<br>300.1210b)<br>300.1210c)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><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 300.1210 General Requirements for Nursing and Personal Care<br><br>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a | S9999 | | |

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comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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.

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These Requirements were not met evidenced by:

Based on observation, interview, and record review the facility failed to ensure resident fall interventions were in place and functioning for one of five (R34) residents reviewed for falls in a sample of 26. This failure resulted in R34 having falls and suffering from nasal bone fractures.

Findings include:

The facility's Fall Prevention policy, dated January 2024, documents "Purpose: To provide as safe an environment as possible by taking measures to prevent falls to the extent possible. Policies: C. Every resident shall have safety measures included in the Care Plan from the time of admission. D. The Care Plan safety measures shall be revised as appropriate after a fall occurs and when deemed necessary by nursing. E. After every fall, the cause of the fall shall be determined if possible and measures taken to prevent a similar occurrence in the future. F. Every employee shall participate in fall prevention by observing and reporting safety hazards."

R34's clinical record documents R34 is severely cognitively impaired with diagnoses including: Vascular Dementia, moderate, with behavioral disturbance, Unspecified Psychosis, Frontal Lobe Deficit following Subarachnoid Hemorrhage, Nontraumatic Subarachnoid Hemorrhage, Weakness, Neuritis, Ataxia, and Anxiety disorder.

On 4/16/24, at 09:51am, R34 sat in her wheelchair with green and yellow bruising noted to both upper cheeks and across her nose. At this time, while feeding R34, V16 Registered Nurse/RN stated that R34 fell about a week ago

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and fractured her nasal bones.

R34's current Care plan documents "(R34) is a high fall risk related to Dementia with poor safety awareness, incontinence, medication side effects, need for assist with ADLs (Activities of Daily Living) and not always being receptive to assistance, combative at times, confusion and history of previous falls." This same Care Plan includes interventions of "Provide resident with silent bed check (bed alarm)" and "Staff to anticipate her needs and support her when her silent bed check is alarming" initiated on 12/29/22; and "(R34) is to only have 1 pillow and 1 blanket in her room" with an approach date of 4/8/24.

R34's Fall Event Report, dated 2/7/24, documents R34's fall occurred in R34's room while ambulating with primary cause listed as "bed alarm not alarming during time of fall". This report also states "New/Additional Fall Prevention Strategies Implemented: Other (be specific) - new alarm pad. What interventions or changes in routine were implemented by staff? - Staff to check bed alarm and replace if needed."

R34's Fall Event report, dated 4/6/24 by V6 Licensed Practical Nurse/LPN, documents the following: R34's fall occurred at 7:55pm, personal alarm is ordered and in use, fell while ambulating. Skin tear and possible facial fracture - await x-rays. Hematoma and skin tear bridge of nose. Last time resident observed 7:25pm in bed awake by V5 Memory Care Coordinator. V17 Certified Nurse Assistant/CNA heard a cry out and found (R34) on floor in small hallway between bathroom and closet. Three blankets noted on floor previously noted on recliner. Primary Cause: Resident carrying multiple

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blankets during ambulation. Care plans: Equipment issue (bed alarm not functioning) referred to Maintenance. Other - Bed alarm replaced and confirmed working status. New/additional fall prevention strategies implemented: Re-arrange furniture/reduce clutter in room. Interventions or changes in routine implemented by staff: Resident to have one pillow and one blanket in her room. Other - She has multiple blankets in her room, three were with her at the time of the fall, most likely she tripped over them.

R34's radiology report, dated 4/7/24, documents: "Intact orbits but nasal bone fracture with several components appearing depressed."

On 4/17/24, at 12:23pm V11 CNA stated "(R34) has a bed alarm so that we are aware of when she gets up and moving and we can assist her." At this time, V11 verified there are two bedspreads on (R34's) empty bed. V11 stated "It is okay since she is not in the bed, it's so she doesn't have as much to get tangled up in. When she is in the room, we make sure things are in order. If we were to put her to bed, we would take one blanket off."

On 4/17/24, at 1:30pm, V10 Director of Memory Care and V13 CNA toileted R34. V13 left the room then V10 assisted R34 to lay down in R34's bed.

On 4/17/24, at 1:43pm, R34 was lying in bed with two bedspreads over her and one pillow under her head. Two Afghan blankets and one pillow were on R34's recliner. At this time V13 CNA verified that R34 has two blankets on her while in bed. V13 stated "She is to have only one pillow and one blanket because she was wrapped up in

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them when she fell; I think it was her personal blankets." V13 verified two Afghan blankets and one pillow were on R34's recliner in (R34's) room.

On 4/17/24, at 1:47pm, V10 Director of Memory Support stated "We felt that layers of blankets on (R34) attributed to her fall (on 4/6/24). The ones with her during the fall are heavier. We use lighter blankets on her now. As for a pillow, sometimes she has one and at times she needs two - depending on the position and angle she is in in her bed. (R34) is a hoarder and gathers blankets and things from her bed and chair. At this time V10 reviewed and confirmed that R34's Care plan states R34 is only to have one blanket and one pillow in her room and that (R34's) room should've had that now. V10 also stated "It is very important to be sure R34's alarm is on when laying her down. You can hear it beep when she sits on it. Whoever lays her down should be sure it's working."

On 4/17/24, between 2:10pm - 2:20pm, V5 Memory Care Coordinator stated that V5 put (R34) to bed prior to R34's fall on 4/6/24. V5 does not recall if there were items on (R34's) bed or recliner. (R34) had a bed alarm. It is under the sheets. I do remember seeing it. It turns on when she sits down. I don't remember hearing it. At this time V5 showed this writer the bed alarm device hanging on the wall behind R34's bed. V5 sat on the bed and the bed alarm device sounded in a short ring tone and a light turned green on the device. When V5 stood up the alarm alerted the nurse call system and the light on this bed alarm device turned red. V5 stated that V5 does not routinely pay attention to the alarm or whether it is functioning or not. "I do not know why she has it." V5 also stated that when V5 put R34 to bed (on 4/6/24) V5 put just one fleece blanket on R34.

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"There might have been another one on her recliner. It is possible for her to take a blanket from the chair. She hoards and gets fixated on things."

On 4/17/24 at 5:10pm, V6 Licensed Practical Nurse/LPN stated, "Basically, we spent a lot of time with (R34) throughout that night (4/6/24). She was restless. Later, a CNA (V17) alerted me that (R34) was on the floor. They said that (V5 Memory Care Coordinator) had assisted (R34) to lie down. When V17 went into (R34's) room and saw (R34) on the floor there were three blankets around (R34). (R34) picks them up and gathers them at times. They were throw blankets. They were on the floor around (R34). They would have been taken from (R34's) recliner chair. I know that because I saw them in that chair earlier, multiple times. (R34's) bed alarm was not sounding according to (V17). We tested it and it was not working. When (R34) lies down it will make a small sound, a beep. Typical protocol is to make sure it is working. I am not sure if it is inspected regularly. (R34) has the bed alarm to alert us when she is up. In a perfect world we would have been able to get to her sooner if it had been sounding. (R34's) bed alarm is a fall intervention to alert us that (R34) is up and so that (R34) doesn't have a fall...This fall's intervention is to have one pillow and one blanket in the room with (R34) when she is in bed, so she doesn't have the ability to gather blankets and fall again. (R34) commonly collects blankets and items."

On 4/18/24, at 2:15pm, V2 Director of Nursing/DON confirmed that R34's bed alarm was not sounding during (R34's) falls on 2/7/24 and 4/6/24 and that (R34's) bed alarm is a fall prevention intervention. V2 stated the following:

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| S9999 | Continued From page 7<br><br>Depending on where staff were at the time of the fall it is possible for them to get into her room in time, but also depending on how fast R34 was moving. I reviewed (R34's) 4/6/24 fall investigation and was told that the blankets were last seen in the chair. V2 verified that R34's Care plan intervention (post 4/6/24 fall) is for one pillow and one blanket in the room - no extra. They are to remove extra blankets from her room and can't have any heavy blankets in there. I had told staff yesterday to remove them once (R34) was lying down. I guess staff didn't think the two Afghans could trip (R34) up. They should have removed them. R34's bed alarm should have been working. Personally, if I laid (R34) down I would check to make sure it was working. It beeps. It's hard to miss it. The idea of the bed alarm is to hopefully be able to get to the resident before they might fall.<br><br>(B) | S9999 | | |