STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

(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 Complaint Investigation 2427910/IL178677	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1010i) 300.1210d)3) 300.3240a) 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 300.1010 Medical Care Policies i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

(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
S9999	Continued From page 1	S9999		

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These regulations were not met as evidenced by:

Based on observation, interview and record review the facility neglected to assess and monitor two residents (R1, R2) post falls, neglected to initiate neurologic checks, neglected to initiate treatment for a head wound, neglected to assess for pain and failed to follow the facility fall and pain management policies of two residents reviewed for change in condition related to falls. This failure resulted in R2 not receiving necessary pain management for a hip fracture for seven hours.

Findings include:

Facility Policy/Residents Right To Freedom From Abuse, Neglect, and Exploitation Policy and Procedure dated 2024 documents:
Purpose: To ensure that all of (the Facility) residents are free from abuse, neglect, misappropriation of their property, and exploitation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

(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
S9999	Continued From page 2 The facility explicitly and expressly prohibits, and will take steps to prevent, any (Employee) from engaging in any behavior or actions that may result in the abuse, neglect, and exploitation of residents and misappropriation of resident property. Facility Policy/Pain Management and Assessment dated 11/22/2021 documents: Evaluation and Assessment: Comprehensive pain assessment tool will be completed upon admission, transfer or onset of new pain which includes: Quality of pain (e.g. burning, aching, numbness) Pain intensity (numeric, visual analog scale, or nonverbal behavior, changes in function observation) Changes in mood state (e.g. depression, anxiety) Location and/or radiation of pain Factors that palliate or provoke pain Characteristics of pain (i. e., stable, progressive, crescendo) Facility Policy/Change in Condition Procedure dated 9/21/2022 documents: The following guidelines will be utilized as appropriate to each situation and change in condition: Full assessment by nursing staff including but not limited to: Full Vital signs (Temperature, Pulse, Respirations, Blood Pressure and Oxygen Saturation) Level of consciousness; Respiratory status including last bowel movement and urine properties Functional status, Pain Glucose test if diabetic or decrease in level of consciousness.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

(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
S9999	Continued From page 3	S9999		

Progress Note dated 9/27/24 at 11:59pm indicates "(R2) on floor, sitting on his bottom. (R2) claims he was looking for his remote. Vital signs within normal limits, no injuries, moves all extremities within normal limits."

Progress Note dated 9/28/24 at 7am indicates R2 complained of hip pain "10/10" after fall last evening. Note indicates "(R2) fell at 11:59pm 9/27/24, now complaining of pain and left leg appears to be externally rotated."

No other progress notes or documentation regarding R2 was found between 9/27/24 at 11:59pm and 9/28/24 at 7am.

Hospital ED (Emergency Department) Final Report Note dated 9/28/24 at 11:14am presented to the ED with left hip pain-swelling, stating he fell last night with pain persisting this AM. Note indicates R2 has a past surgical history of right hip fracture.

Risk Management Incident Report dated 9/27/24 at 11:51pm indicates (R2) Level of Pain (post fall): "Alert; wheelchair bound." Report does not include any actual documentation of R2's pain post fall.

On 10/22/24 at 11:40am V6, CNA stated after she found R2 on the floor, she called V3, LPN who came in and "barely did an assessment" of R2 and then helped her get R2 back into his wheelchair. V6 stated she was holding the top half of R2 and V3 was holding his bottom half. V6 stated R2 was complaining of pain while they were trying to get him into the chair. V6 stated that night R2 would complain of pain and yell "Ow!" every time they turned and changed him when he was in bed, especially when turned to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

(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
S9999	Continued From page 4	S9999		

the left side. V6 stated R2 really couldn't roll onto the left side. V6 further stated "When I found (R2) on the floor, he was completely on his left hip/side. He must have hit hard because the sound I heard from the nurses station was loud." V6 stated she did notify V3 about R2's pain throughout the night.

On 10/22/24 at 12:30pm V3, LPN stated "I rely on the CNA's to tell me. It was a busy night, I didn't reassess him (R2). I gave (R2) meds in the morning (not for pain), he took it ok."

On 10/18/24 at 11:30am V5, LPN (Licensed Practical Nurse) stated she was told in report in the morning of 9/28/24 that R2 had an unwitnessed fall during the night (of 9/27/24) and was on neuro(logical) checks. V5 stated a CNA came to tell her that while she was providing cares to R2, he was complaining of pain on his left side. V5 stated the night nurse (V3) didn't say anything to her in report about R2 being in pain during the night. V5 stated R2 was in a great deal of pain "especially with any movement."

No documentation of R2's pain at time of fall or anytime between time of fall at 11:59pm through 7am the following morning (9/28/24) was found or presented. No assessment or interventions to relieve R2's pain from after he fell was found or presented until the morning of 9/28/24 at 7am.

On 10/23/24 at 4:30pm V11, Medical Director stated there can be severe pain associated with a hip fracture, especially with movement. V11 stated there should be a policy to assess for pain after a fall and the policy should be followed.

2) Facility Policy/Fall/Accident/Incident Protocol dated 8/1/22 documents:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

(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
S9999	Continued From page 5	S9999		

The following guidelines will be utilized as appropriate to each situation and change in condition:
Nursing evaluation on all resident falls, witnessed and unwitnessed
Complete set of vital signs (temperature, pulse, respirations, blood pressure and oxygen saturation) including pulse oximetry
Neuro-checks to be initiated with every un-witnessed fall and witnessed fall with head injury
Contact On-call Nurse
Notify physician
Notify family
Document progress note (May complete in Risk Management)
Complete Risk Management
Obtain complete vital signs including pulse oximetry at a minimum of every shift for 72 hours
Document in chart minimum of 72 hours post fall.

Progress Note dated 9/27/24 at 11:17pm indicates R1was found on the floor on his bottom. Note indicates a head to toe assessment was done and a small amount of blood was found on the top of R1's head "Looked like a scab that he picked." Note indicates (V3, LPN/Licensed Practical Nurse) used a (tissue) to clean the area with no active bleeding noted.

Progress Note dated 9/28/24 at 6:25am indicates at 6:05am report received from night nurse that R1 was in bed with no new or ongoing concerns. Note indicates at 6:25am dayshift V4, CNA (Certified Nurse Assistant) notified V8, LPN/ (Licensed Practical Nurse) that R1 had a bump on his head that was bleeding. Note indicates V4, CNA stated he received in report from V6, CNA that R1's head was "bleeding all night." Note indicates V8, Nurse immediately entered R1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

(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
S9999	Continued From page 6	S9999		

room and assessed R1. Note indicates a palm-size raised bruise was noted to the back of R1's head with a "laceration" noted to the center of the bump with blood dripping. Note indicates quarter-size drops of blood were noted to multiple areas of R1's pillowcase. Note indicates when asked, R1 stated he fell last night at 10:30pm with complaints of pain to the back of his head. Note indicates R1 was then transferred to the hospital for evaluation.

Hospital Emergency Department (ED) Report dated 9/28/24 at 6:52am indicates R1 was found to have a bruise on the back of his head that had a small amount of blood. Note indicates R1 stated he may have had a seizure and fallen "last night."
Hospital Report indicates R1 was diagnosed with a Scalp Contusion.

On 10/22/24 at 10:10am R1 was sitting in his room watching television. R1 was able to recall falling and hitting his head. At that time a linear approximately 4cm (centimeter) dark pink, slightly scabbed area to the posterior top part of R1's head was noted.

On 10/22/24 at 11:46am V6, CNA stated "On Friday night (9/27/24) I found (R1) sitting on the floor leaning against his bed. When (R1) laid down I noticed a small amount of blood on his head. I told the nurse (V3) and she did "somewhat of an assessment" and wiped the blood away with one of R1's tissues. She said he was "Ok." She never started neuro checks or anything else." V6 stated R1's head continued to bleed all night "The other CNA (V7) noticed it too. The nurse was aware. It was not right. I told my boss (V1, Administrator) exactly what happened."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

(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
S9999	Continued From page 7	S9999		

On 10/22/24 at 11:22am V4, CNA stated he came on shift and got a brief report and was told R1 had hit his head when he fell the night before, but it stopped bleeding. V4 stated he went to see R1 and noticed blood scattered on his pillow case. V4 stated he saw swelling and a "knot" on R1's head and "It was still dribbling blood at that time." V4 stated he immediately went and told the V8, LPN who also had just received morning report. V4 stated that V8, LPN replied that she had received no information about R1 in report and had no idea what happened to R1.

On 10/22/24 at 12:30pm V3, LPN stated that V10, CNA told her that R1 (on 9/27/24) was on the floor. V3 stated R1 has behaviors of putting himself on the floor. V3 stated a short while later V6, CNA told her there was a small amount of blood on R1's head. V3 stated she had already looked at R1's head and there was no swelling, and she had wiped the area with one of R1's tissues. V3 stated she didn't believe R1 fell and thought it was R1's "behaviors" so she didn't do neurological checks. V3 stated she didn't notify the physician and didn't notify R1's family. V3 stated R1's POA (Power of Attorney) said she doesn't want to hear about his "Bullcrap" so she didn't bother her. V3 stated R1 denied falling, but could not explain how he got on the floor. V3 stated she was aware of R1's seizure diagnosis but believed it was one of R1's "behaviors." V3 stated she didn't hear from R1 or the CNA's for the rest of the night so she didn't check on R1 again during the night.

On 10/22/24 at 12:50pm V7, CNA stated that she went to see R1 shortly after he fell. V7 stated that R1 told her he fell but he seemed "ok." V7 stated there was blood on his pillow and it "looked like he hit his head." V7 stated that she reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

(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
S9999	Continued From page 8	S9999		

what she saw to the nurse (V3) and told her there was blood and (V3) said she already assessed R1. V7 stated "I don't think she (V3) went back in to see him."

On 10/22/24 at 2:15pm V1, Administrator stated staff should not disregard and not follow the fall protocol just because someone has behaviors.

On 10/23/24 at 4:32pm V11, Medical Director stated there should be a policy and the staff should follow the policy for what to do when someone falls and when someone hits there head. V11 stated "Staff should not minimize or disregard incidents because someone has behaviors, but should actually do more to make sure they are ok."

On 10/23/24 at 3:05pm V2, DON (Director of Nursing) stated all employees are trained on the facility policies and should follow them.

V3, LPN was aware of the facility policies regarding post fall monitoring and pain management and neglected to provide treatment to R1's head wound including neurological checks and failed to assess and monitor R2 for pain and potential injury after both R1 and R2 sustained unwitnessed falls despite being notified by staff of the residents need for care and treatment. V3's neglect of R1 and R2 after they fell on 9/27/24 at 11:59pm resulted in indifference and disregard for the care, comfort and safety of R1 and R2.

(No Violation)

Statement of Licensure Violations (2 of 2)

300.610a)
300.1210a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

(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
S9999	Continued From page 9 300.1210d)3) 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 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 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) d) Pursuant to subsection (a), general nursing	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

(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
S9999	Continued From page 10	S9999		

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.

These regulations were not met as evidenced by:

Based on observation, interview and record review the facility failed to assess, document and provide pain management for one resident (R2) of three residents reviewed for change in condition. This failure resulted in no pain management provided for 7 hours after R2 fell and sustained a left hip fracture.

Findings include:

Facility Policy/Pain Management and Assessment dated 11/22/2021 documents:
Evaluation and Assessment: Comprehensive pain assessment tool will be completed upon admission, transfer or onset of new pain which includes:
Quality of pain (e.g. burning, aching, numbness)
Pain intensity (numeric, visual analog scale, or nonverbal behavior, changes in function observation)
Changes in mood state (e.g. depression, anxiety)
Location and/or radiation of pain
Factors that palliate or provoke pain
Characteristics of pain (i. e., stable, progressive, crescendo)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

(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
S9999	Continued From page 11	S9999		

Facility Policy/Change in Condition Procedure dated 9/21/2022 documents:
The following guidelines will be utilized as appropriate to each situation and change in condition:
Full assessment by nursing staff including but not limited to:
Full Vital signs (Temperature, Pulse, Respirations, Blood Pressure and Oxygen Saturation)
Level of consciousness;
Respiratory status including last bowel movement and urine properties
Functional status, Pain
Glucose test if diabetic or decrease in level of consciousness.

Progress Note dated 9/27/24 at 11:59pm indicates "(R2) on floor, sitting on his bottom. (R2) claims he was looking for his remote. Vital signs within normal limits, no injuries, moves all extremities within normal limits."

Progress Note dated 9/28/24 at 7am indicates R2 complained of hip pain "10/10" after fall last evening. Note indicates "(R2) fell at 11:59pm 9/27/24, now complaining of pain and left leg appears to be externally rotated."

No other progress notes or documentation regarding R2 was found between 9/27/24 at 11:59pm and 9/28/24 at 7am.

Hospital ED (Emergency Department) Final Report Note dated 9/28/24 at 11:14am presented to the ED with left hip pain-swelling, stating he fell last night with pain persisting this AM. Note indicates R2 has a past surgical history of right hip fracture.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

(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
S9999	Continued From page 12	S9999		

Risk Management Incident Report dated 9/27/24 at 11:51pm indicates Level of Pain (post fall): "Alert; wheelchair bound." Report does not include any actual documentation of R2's pain post fall.

On 10/22/24 at 11:40am V6, CNA stated that she was sitting at the nurse station and heard a loud "thud." V6 stated she left the nurses station and followed the sound of the "thud" and saw R2 on the floor in front of the sink. V6 stated R2's room is almost right next to the nurse station, R2's television is above the sink and R2 said he was trying to turn the television on. V6 stated she called V3, LPN who came in and "barely did an assessment" of R2 and then helped her get R2 back into his wheelchair. V6 stated she was holding the top half of R2 and V3 was holding his bottom half. V6 stated R2 was complaining of pain while they were trying to get him into the chair. V6 stated that night R2 would complain of pain and yell "Ow!" every time they turned and changed him when he was in bed, especially when turned to the left side. V6 stated R2 really couldn't roll onto the left side. V6 further stated "When I found (R2) on the floor, he was completely on his left hip/side. He must have hit hard because the sound I heard from the nurses station was loud." V6 stated she did notify V3 about R2's pain throughout the night.

On 10/22/24 at 12:30pm V3, LPN stated that she went to R2's room when she heard he was found on the floor. V3 stated that she and V6, CNA manually picked R2 up and put him in his wheelchair. V3 stated "(R2) had no complaints of pain. V3 stated "I rely on the CNA's to tell me. It was a busy night, I didn't reassess him. I gave (R2) meds in the morning (not for pain), he took it ok. There is not a spot to document pain on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

(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
S9999	Continued From page 13	S9999		

Neuro sheet. I should've put in a progress note about R2's pain assessment."

On 10/18/24 at 11:30am V5, LPN (Licensed Practical Nurse) stated she was told in report in the morning of 9/28/24 that R2 had an unwitnessed fall during the night (of 9/27/24) and was on neuro(logical) checks. V5 stated a CNA came to tell her that while she was providing cares to R2, he was complaining of pain on his left side. V5 stated the night nurse (V3) didn't say anything to her in report about R2 being in pain during the night. V5 stated she had another nurse (V8) came into R2's room and they both agreed R2 needed to go to the hospital for evaluation. V5 stated R2 was in a great deal of pain "especially with any movement."

No documentation of R2's pain at time of fall or anytime between time of fall at 11:59pm through 7am the following morning (9/28/24) was found or presented. No assessment or interventions to relieve R2's pain from after he fell was found or presented until the morning of 9/28/24 at 7am.

Medication Administration Record (MAR) dated September 2024 indicates no pain medication was administered during the night of 9/27/24 through 9/28/24.

Current Care Plan has no focus/problem area identifying R2's pain or interventions for pain management.

On 10/22/24 at 10am R2 was sitting in his room in his wheelchair with a distressed facial appearance. R2 stated his back hurt and he wanted to lay down. R2 became teary-eyed while speaking. R2 stated this latest hip fracture was much more painful than his previous (right) hip

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

(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
S9999	Continued From page 14 fracture. R2 was unable to recall anything else from the night he fell (on 9/27/24) other than he was trying to turn on the television. At that time V5, LPN came in to assess R2 and stated that R2 is easily "emotional" especially when in pain. On 10/23/24 at 4:30pm V11, Medical Director stated there can be severe pain associated with a hip fracture, especially with movement. V11 stated there should be a policy to assess for pain after a fall and the policy should be followed. (B)	S9999		