STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003578	A. BUILDING: _____ B. WING _____	C 01/04/2025

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S 000	Initial Comments Invesigation of Facility Reported Incidents of 12/13/24/IL183216	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210a) 300.1210b) 300.1210d)6) 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. 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	S9999		

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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 were not met as evidence by:

Based on interview and record review, the facility failed to adequately assess and supervise a cognitively impaired resident for the use of an electric assisted standing recliner for one (R1) of three residents reviewed for accidents on the sample list of five. This failure resulted in R1 falling and receiving a left subdural hematoma and a nondisplaced fracture of the left frontal bone.

Findings include:

R1's Minimum Data Set (MDS) dated 11/25/24 documents R1's Brief Interview for Mental Status (BIMS) score 8, moderate cognitive impairment, needed substantial assistance with Activities of Daily Living (ADL), wheelchair bound and dependent on staff to and unable to ambulate.

R1's Fall Risk Evaluation dated 11/16/24 documents R1 was at risk for falls.

R1's Care Plan dated 11/26/24 documents; Fall

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Risk: R1 has the potential for falls due to current medical conditions and Gait/Balance problems, Restorative: R1 has limited physical mobility related to weakness.

R1's Chair/bed-to-chair transfer Task dated 12/13/24 at 6:18am documents: R1's ability to transfer from bed to wheelchair. V7 (Certified Nursing Assistant/CNA) documented R1 dependent-Helper does all the of the effort. R1 does none of the effort to complete the activity, or the assistance of 2 or more helps is required for the resident to complete the activity.

On 1/4/25 at 11:50am, V7 (CNA) said, on 12/13/24 V7 was working the 6:00am - 2:30pm shift and that R1 was in V7's group. V7 said, R1 is a 2-person mechanical lift transfer, or a 2-person gait belt transfer. V7 said, V7 would have last changed R1 between 1:00 and 2:00pm due to V7 always conducting rounds after lunch. V7 said, R1 was in R1's electric assisted standing recliner when V7 left work at 2:30pm on 12/13/24. V7 said, R1's electric assisted standing recliner did have a remote to use to assist with standing, and V7 would use it sometimes to assist with getting the mechanical lift hooked up to transfer R1. V7 said, V7 would than pin the remote not in reach of R1, so that R1 would not have access to the remote to lift the chair in an upright position.

On 1/4/25 at 12:12pm, V8 (Occupational Therapy) said, R1 was on therapies case load, and on 12/13/24 R1 was either a 2 person stand pivot transfer using a gait belt, or a 2-person mechanical lift transfer. V8 stated that R1's family brought R1's electric assisted standing recliner in from home, due to R1 slept and sat in it at home. V8 stated, R1's electric assisted standing recliner had a remote that when activated it would assist

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with standing R1 into an upright position. V8 stated when V8 was done providing therapy to R1, V8 would not place the electric assisted standing recliner remote in eye contact of R1's vision, due to R1 liked to fidget with things, such as the television remote, call lights and anything that R1 could reach. V8 stated that therapy did not attempt to educate R1 in using the remote for the electric assisted standing recliner, due to R1 being a 2-person assist with transfers, and R1's cognitive impairment.

On 1/4/25 at 12:41pm, V6 (CNA) stated that on 12/13/24, V6 was working the 2:00pm-10:30pm shift, and R1 was not in V6's group. V6 stated that at 3:30pm, V6 was told that R1 was on the floor in R1's room. V6 stated when V6 got to R1's room, R1 was laying on the floor in front of R1's electric assisted standing recliner on R1's left side, and that recliner was lifted all the way up in a standing position.

On 1/4/25 at 1:13pm, V5 (Restorative Assistant) stated that V5 had conducted therapy with R1 and that R1 was a 2-person assist with a gait belt or 2 assist mechanical lift. V5 stated that on 12/13/24 at 3:30pm, V5 was walking down the hallway and heard R1 calling for help. V5 stated upon entering R1's room, V5 observed R1 laying in front of R1's electric assisted standing recliner which was in the up position. The up position would make R1 stand. V5 stated that V5 went and notified V3 (Registered Nurse/RN) that R1 had fallen.

On 1/4/25 at 1:40pm, V2 (Director of Nursing) stated that V2 conducted the investigation regarding R1's fall. V2 stated that V2 attempted to interview R1 after returning from the hospital and R1 was unable to provide any details of the

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fall. V2 stated after interviewing staff, V2 learned that on 12/13/24 at 3:30pm, V5 heard R1 calling for assistance from R1's room. Upon V5 entering R1's room, V5 observed R1 on the floor on R1's left side, and R1's electric assisted standing recliner was in the upright standing position. V2 stated that V6 (CNA) confirmed that R1 was observed on the floor in front of R1's electric assisted standing recliner in an upright standing position. V2 stated that V3 (RN) also confirmed that upon entering R1's room, V3 observed R1 laying on R1's left side in front of R1's electric assisted standing recliner, which was in the up position, and that R1 had a hematoma to the left side of R1's forehead. V2 stated that V3 obtained orders and sent R1 to the emergency room for evaluation, and the facility was informed by the hospital that R1 had sustained a left subdural hematoma and a nondisplaced fracture of the left frontal bone.

On 1/4/25 at 2:10pm, V3 (RN) stated that on 12/13/24 at 3:30pm, V5 informed V3 that R1 had fallen in R1's room. V3 stated that V3 immediately went to R1's room and upon entering observed R1 laying on the floor on R1's left side, and R1's electric standing assisted recliner was in a standing upright position. V3 stated V2 assessed R1 and noted a hematoma to the left side of R1's forehead. V3 stated that R1 was unable to provide any information on how R1 had fallen. V3 stated V3 called the facility physician and got an order to send R1 to the emergency room for evaluation.

R1's Facility Census documents R1 was admitted to the facility on 11/15/24 and was discharged on 12/26/24 and had the following medical diagnoses; Encounter for Palliative Care, Traumatic Subarachnoid Hemorrhage, Displaced

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Spiral Fracture of Shaft of Left Femur, Encounter for Orthopedic Aftercare, Multiple Fractures of Ribs Right Side, Atrial Fibrillation, Atherosclerotic Heart Disease, Sjogren Syndrome, Dysphagia Oropharyngeal, Cognitive Communication Deficit, Lack of Coordination, Weakness, Long Term Use of Non-Steroidal Anti-Inflammatories (NSAID), Abnormalities of Gait and Mobility, Muscle Weakness, Person Injures in Motor-Vehicle Accident, Presence of Coronary Angioplasty Implant and Graft, Hyperlipidemia, HTN, Osteitis Deformans of Multiple Sites and Peptic Ulcer.

R1's Post Fall Evaluation Dated 12/13/24 at 3:30pm documents; Fall Details: Date/Time of Fall: 12/13/24 at 3:25pm, Fall was not witnessed. Fall occurred in R1's room. Activity at the time of fall: R1 was using R1's remote to get up out of R1's recliner chair. The reason for the fall was not evident. Did an injury occur as a result of the fall: Yes. Injury details: R1 had a hematoma to the left side of R1's forehead. Did fall result in Emergency Room (ER) visit/hospitalization.

R1's Hospital Medical Imaging Report dated 12/13/24 documents CT scan head without contrast. Findings: The visualized base of skull structures appear intact. A scalp hematoma in the left frontal scalp is noted. This hematoma in the frontal scalp measures 8 millimeters in thickness. A subtle fracture of the left frontal bone is noted. This appears nondisplaced in the nature is appreciated best on coronal imaging. A moderately large subdural hematoma along the left parietal region is seen, measuring 10.5 millimeters in thickness. The midline of the cerebral falx is displaced towards the right by as much as 4.8 millimeters. Chronic appearing decreased attenuation in the left frontal deep white matter is seen, suggesting an area of

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S9999	Continued From page 6 encephalomalacia and probable prior white matter. This area of encephalomalacia was seen on 11/18/24. The left subdural hematoma represents new findings. Impression: Scalp hematoma in the left frontal area is seen. A nondisplaced fracture of the left frontal bone is suspected on this exam. Slight shift of the midline towards the right is seen, as described above. Chronic periventricular white matter small-vessel disease changes suggesting microvascular angiopathy changes and an area of encephalomalacia in the left frontal area is seen but appears unchanged since 11/18/24. (A)	S9999		