STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING _____ B. WING _____	C 09/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

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S 000	Initial Comments Complaint # 1845970/IL105704 F684, F689 Complaint # 1846030/IL105765	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)6) 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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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. 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 REQUIREMENTS WERE NOT MET EVIDENCED BY: Based on observation, record review, and interview, the facility failed to provide professional standards of care to prevent injury from a fall for 1 of 7 residents (R2), reviewed for accidents, in a sample of 16. This failure resulted in R2 sustaining a distal femoral shaft fracture and subarachnoid hemorrhage to her left parietal lobe.	S9999		

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S9999	Continued From page 2 Findings Include: On 9/13/18 at 10:45AM, R2 was lying in bed with a floor mat next to her bed. R2 was asleep with a leg brace on her left lower extremity. A laminated star was affixed to the outside of R2's door. R2's Minimum Data Sets (MDS), dated 6/15/18 and 9/5/18, both document R2 being extensive assistance with transfers and bed mobility. R2's Care Plan revised on 9/11/18, documents in part, R2 having Activities of Daily Living (ADL) self-care deficits related to impaired mobility/balance, and having a left femur fracture on 9/5/18 with no surgical intervention, but does not list R2 having a subarachnoid hemorrhage. The Care Plan also documents R2 needing assistance with ADLs, requiring a knee extension brace on at all times, and non-weight bearing to her left lower extremity. The Care Plan further documents R2 is at risk for falls related to having history of falls. R2's Care Plan dated 10/13/17 documents R2 being a partial mechanical lift. R2's Care Plan revised on 9/11/18 documents R2 being a full mechanical lift for transfers. Fall Risk Evaluation dated 9/4/18 documents R2 scoring 16, indicating high risk for falls, legally blind, and intermittent confusion. Nursing Note dated 9/5/18 at 2:00PM, documents in part, "Staff member entered room approximately 5:15AM noted resident lying on the ground next to bed with a large amount of water on the floor. Per staff member, resident stated "I fell out of bed." "Resident was assisted up "x (times) 1" to bed to get ready for the day.	S9999		

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S9999	Continued From page 3 Facility Incident/Accident Report dated 9/12/18 at 12:30PM, documents in part, R2 having sustained a fall on 9/5/18 at 5:15AM. The report also documents in part, that V21, Certified Nursing Assistant (C.N.A.), entered R2's room and noted R2 lying on the ground next to her bed, and V21 assisted "(R2) to bed to get ready for the day." After a while, "(R2) began complaining of a headache and left leg pain." The report also documents R2 was sent to the Emergency Room (ER), and while there, received a Computed Tomography (CT) scan and X-Rays that revealed a distal femoral shaft fracture and "Intraparenchymal hemorrhage or tiny subarachnoid hemorrhage in the left parietal lobe." The Report further documents R2 returned to the facility on 9/7/18 with a knee brace on her left leg, with no surgical intervention planned. Nursing Note dated 9/7/18 at 6:40PM, documents in part, "(R2) arrived on a stretcher. Transferred to her bed with three assist and did cry out with pain in her leg." Physician's Orders dated 9/7/18, documents in part, "Comfort Measures Only (Allow Natural Death) Relieve pain and suffering through the use of medication by appropriate route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location. Treatment Plan: Maximize comfort through symptom management." Physician's Orders dated 9/15/18, documents R2 to receive Hospice services.	S9999		

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Skilled Nursing Note dated 9/14/18, documents, R2 recently returned from being hospitalized due to a fall resulting in a left femur fracture with conservative management and non-weight bearing status, and being a full mechanical lift for all transfers, with an assist of two.

R2's Electronic Health Record (EHR) dated 9/7/18, documents in part, R2 having a left femur fracture and legal blindness, and a date of birth of 2/3/1914. The EHR fails to documents R2 having a subarachnoid hemorrhage upon return from the hospital on 9/7/18.

Facility Separation Report for V21, CNA, dated 9/7/18, documents in part, "Violation of Company Policy. Facts of Incident: Failure to report a fall that resulted in serious injury to resident."

Training Sign in Sheet dated 8/13/18, documents V21, CNA, was provided training on "New Hire" partial mechanical and full mechanical lifts and their uses.

V21, CNA's statement dated 9/5/18, documents in part, "(R2) fell out of bed I then put a gait belt around her and lifted her back on the bed I then got her up and put her in the chair she (R2) told me she was having pain in her leg I told the nurse she was having pain and that she may be hurt. (sic)"

V12, Licensed Practical Nurse (LPN), statement dated 9/5/18, documents in part, "Around 5 or 5:30 I was called to (R2's) room by her CNA (V21) to investigate c/o(complaints of) LLE(left lower extremity) pain. (R2) was sitting in her wheelchair inside the doorway. (V12) noted edema, redness & (and) warmth to (R2) L(left)

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thigh down through her knee with c/o(complaints of) extreme pain." V12's statement further documents that because R2 was having difficulty with pain control, she was sent to the ER.

On 9/17/18, at 10:30AM, V2, Director of Nursing (DON), stated in part, "(V21, CNA) knew she shouldn't have picked up (R2), and she didn't tell the nurse until after (R2) complained of pain." V2, DON, further stated, V21, CNA, not only put R2 in bed after sustaining a fall, V21 moved R2 again by transferring her from the bed to the chair after getting her dressed for the day. V2 further stated she would've expected staff to get the nurse to assess any resident with any fall, before moving a resident.

On 9/18/18 at 9:00AM, V1, Administrator, stated she had a meeting with the family of R2 recently and came to the conclusion that R2 most likely didn't roll out of bed.

On 9/13/18 at 10:51AM, V4, Registered Nurse Manager (RN), stated in part, that R2 "doesn't move, so not a 100% sure, but (R2) was placed back into bed by the CNA (V21)," and didn't notify the nurse (V12) of the fall and only notified the nurse (V12) of R2's leg pain, and that's when the nurse went to assess the resident. The nurse wasn't told of the fall until the resident was back in bed and fully dressed. V4, RN further stated R2 was a partial mechanical lift prior to the fall and is now a full mechanical lift.

On 9/18/18 at 1:35PM, V25, family member, stated when she was at the hospital on 9/5/18 with R2, the ER staff stated that R2 "fell when going from the bed to the wheelchair," and the resident is not ambulatory. V25 also stated R2 was not noted prior to the 9/5/18 fall to have

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S9999	Continued From page 6 moved independently in bed. V25 further stated V26, transportation coordinator, called her on 9/5/18 at approximately 7:00AM, to inform her that R2 was being sent to the hospital and when V25 asked what happened, V26 stated " R2 fell or could have been dropped by the CNA." Facility Policy entitled Fall Prevention, dated 2/2/2010, and revised on 10/18/2013, documents in part, Falling Start Protocol. The Falling Star Protocol is a facility-based portion of the Fall Management Program. A resident qualified for the Falling Star Program if "Experience a change in condition or decline in ADLs." Facility Policy entitled Mechanical Lift Transfers, revised on July 8, 2016, documents in part, "Policy. To identify and designate residents who require assistance to transfer by a mechanical lift for the safety of both residents and staff member." The Policy further documents in part, "Procedure. 2. Use two staff members when transferring a resident on sling mechanical lift." Facility Occurrence and Event Policy revised on May 14, 2013, documents in part, "Procedures. Care of the Resident. 1. Assess the resident for any injury. 2. If assistance is needed, summon help." (A)	S9999		