STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004444	A. BUILDING: _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTGOMERY NURSING & REHAB CTR	9086 IL ROUTE 127, P O BOX 309 HILLSBORO, IL 62049

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S 000	Initial Comments Complaint #1941893/IL00110428	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.120d)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 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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.

These regulations were not met as evidenced by:

Based on interview, observation and record review, the facility failed to assess and identify the root cause of falls and develop/implement an effective falls prevention plan for 1 of 3 residents (R2) reviewed for falls in a sample of 7. This failure resulted in R2 having multiple falls with the last occurring on 3/10/19 where she sustained a fractured nasal bone and laceration requiring 10 sutures.

Findings include:

1. The Minimum Data Set (MDS) dated 1/11/19 identified R2 as having severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 6 requiring minimal assist of one staff for transfers, walk in room and corridor with assist and walker.

On 3/20/19 at 10am, R2 was sitting in the hallway and had extensive bruising of yellow to various

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shades of red to purple across her entire face extending down into her neckline. R2 had a large laceration with sutures mid to left forehead. R2 had a pressure pad alarm under her.

A Fall Risk Assessment dated 3/10/19 identifies R2 to be high risk.

The Fall Log provided by V2 Director of Nursing (DON) on 3/20/19 identifies R2 to have had unwitnessed falls on 11/5/18 and 11/9/18. From 1/1/19 through 3/10/19, R2 was documented as falling on 1/12/13, 1/13/19, 1/26/19, 1/28/19, 2/21/19, 2/25/19 and 03/10/19. Of these falls, three (2/25/19, 2/21/19, and 1/13/19) were documented as having the alarm sounding with staff being unable to reach her before she fell to the floor.

Progress notes entered on 3/10/19 at 12:40am document R3's alarm was sounding and when staff responded, she was found on the floor by the bathroom door with a large amount of blood on her face with a 2cm x 21cm laceration to her forehead. The note documents 911, was called and R2 was sent to the emergency room for evaluation.

Progress notes dated 3/10/19 at 6:45am document R2 returned to the facility with a fractured nasal bone and 10 sutures to her forehead.

A timeline provided by V2 on 3/21/19 at 10:30am documents interventions added as a result of falls are as follows: 1/12/19 - encourage resident to call for assistance with Activities of daily living, 1/13/19 - pressure pad alarm, 1/26/19 - staff to remind resident to ensure back of legs are touching recliner when sitting in recliner, 1/28/19 -

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encourage resident to attend activities, 2/21/19 - encourage resident to use walker at all times, 2/25/19 - continue to remind resident to call for assistance with transfers and on 3/10/19 - 2 hour toileting. Most of these interventions added based on the residents ability to remember to do things and are questionably effective given R2's severe cognitive impairment.

On 3/21/19, a comprehensive fall assessment was requested with none provided.

On 3/21/19 at 10:30am, V20 Care Plan Coordinator (CPC)/Licensed Practical Nurse (LPN) described R2 as "impulsive" getting up numerous times a day unassisted thinking she can walk when she can't as her gait is very unsteady. V20 stated R2 has experienced an overall decline in activities of daily living since late last fall. V20 stated care plan interventions were added to the fall's prevention plan to remind her to call for staff, etc., but agreed are probably not effective given her cognitive status. V20 stated they have considered room changes for others to increase visibility but didn't say they had for R2 and acknowledged that her room is over 1/2 way down the hall from the nurse's station.

On 3/21/19 at 1pm, V4 LPN stated R2 is very impulsive and quick adding that she can get across a hallway before staff can get to her. V4 stated R2's gait is very unsteady. V4 stated R2 doesn't realize she can't walk but reminding her to call for assistance just doesn't work because she doesn't remember. V4 stated R2's alarm may go off 3-4 times a shift at least. V4 stated R2 can be aggressive at times with staff and doesn't always respond to redirection to sit down.

On 3/21/19 at 1:36pm, V7 Social Service

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Designee (SSD) stated R2 is very impulsive and gets up repeatedly without staff. V7 stated it would not work to remind R2 to call for help due to her cognitive impairment. V7 stated they have moved R2 up the hall a little as she used to be in the last room at the far end.

On 3/21/19 at 2:15pm, V17 Certified Nurse Aide (CNA) stated R2 has no safety awareness and will at times, remove her alarm and take it with her when she gets up. V17 stated she's very confused and will only at times, follow redirection. V17 stated sometimes she just wants to walk. V17 stated if you hear her alarm "you better go running" because she is quick. V17 stated she is also "very motherly" and likes to check things out if she hears other residents having a problem which will cause her also to get up. .

On 3/21/19 at 3pm, V22 Physical Therapist Aide (PTA) stated R2 has been on therapy since 1/23/19 due to a decline in mobility and increased weakness. V22 stated R6 can make her needs known like needing to use the toilet etc., but is very difficult to redirect. V22 stated R2 wouldn't necessary use a call light or ask for assistance but would just get up and go stating she agreed that the facility should identify the issue of her getting up and moving quickly as a problem with interventions being specific to that.

Physical Therapy notes for service from 1/23/19 to 3/23/19 documents justification for skilled services "remaining impairments: balance deficits, strength impairments and vestibular system deficits."

R2's care plan dated 1/18/19 identifies R2's problems as "at risk for falls or trauma, as res has alteration in mobility, hx (history) of falls" with a

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S9999	Continued From page 5 goal to "not experience injury r/t (related to) falls thru next review" but fails to identify R2's primary cause of falling is her impulsiveness in getting up unassisted thinking she can walk and her lack of safety awareness. Interventions reflect the ones given on the time line in part but none address the need for staff to immediately respond to R2's alarm, R2's impulsiveness, frequency at getting up unassisted and her need for increased monitoring which is the root cause of most of her falls. The facility's policy/procedure entitled "Falls Management" dated December 2016 documents it is the policy to assess and manage resident falls through prevention, investigation, and implementation and evaluation of interventions. (B)	S9999		