STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002877	A. BUILDING: _____ B. WING _____	C 08/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EUNICE C SMITH NURSING HOME	1251 COLLEGE AVENUE ALTON, IL 62002

(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 #1945527/IL114364	S 000		
S9999	Final Observations Statement of Licensure Violations. 300.610 a) 300.1210 d) 6) 300.3240 a) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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 and record review the facility failed to provide assistance to prevent a fall for 1 of 7 residents (R2), reviewed for falls in the sample of 9. This failure resulted in R2's fall sustaining a right distal femur (leg) fracture.

Findings include:

R2's Minimum Data Set (MDS), dated 7/9/19, documents R2 had a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition intact. The MDS further documents R2 requiring extensive assistance of two persons physical assist with bed mobility and transfers.

R2's Fall Risk Assessment, dated 7/26/19, documents R2 scoring a 50, indicating high risk for falls.

On 8/11/19 at 11:44 AM, R2 stated she was initially admitted to the facility to get therapy. R2 stated on the date she fell (7/26/19), she needed to sit up on the side of the bed to get ready for her appointment with the wound center, and was in need of staff assistance. R2 stated the Certified Nursing Assistant (CNA) (V3) had removed the "bumpers" from the sides of the bed. V3 had a hold of her (R2's) left hand. V3 let go of her (R2's) hand and walked towards the foot of

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S9999	Continued From page 2	S9999		

the bed and R2 "slid right off the bed." R2 stated the pain comes and goes, and "it's painful" with any movement. R2 further stated she had informed the facility multiple times about the bed being so slick.

On 8/9/19 at 10:42 AM, V4, Nurse Practitioner (NP), stated she was at the facility on 7/26/19 when R2 sustained a fracture to her right leg. V4 stated R2 told her she landed on her knee when she fell out of bed. V4 further stated the best standard of practice is to not move a resident with a suspected fracture, but the staff had already put R2 back to bed when she went to assess R2 after her fall. V4 also stated she sent R2 to the ER (Emergency Room) for evaluation and treatment of her leg fracture.

On 8/9/19 at 10:04 AM, V3, CNA, stated she has only been employed with the facility since 6/2019 as a CNA. V3 stated she answered R2's call light and noted R2 was on a low air loss bed that was "slick," and that R2 could "pretty much do it (sit up) herself," while in bed. V3 further stated that R2 complained of pain in her right knee and "was very uncomfortable." V3 stated the bed was slick, and V3 couldn't stop R2 from falling.

On 8/9/19 at 2:12 PM, V10, CNA, stated he assisted V3, CNA, with putting R2 back to bed after she fell. V10 further stated R2 didn't want anyone to touch her, R2 expressed pain in her knee, and "we were holding it the whole time."

On 8/9/19 at 8:47 AM, V2, Director of Nursing (DON), stated she assessed R2 on 7/26/19 when R2 fell out of her bed. V2 stated the CNAs (V3 and V10) assisted R2 back to bed with a full mechanical lift. V2 further stated she then requested the NP to come and assess R2 at

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S9999	Continued From page 3	S9999		

bedside.

On 8/11/19 at 10:12 AM, V2 stated, "Yes, two people for bed mobility was the case because (R2) is a large lady and the MDS did say extensive assist with bed and transfers," and V2 was aware V3, CNA, had assisted R2 without any assistance from additional staff.

R2's Hospital records, dated 7/26/19, document, "(R2) presented to the emergency room via EMS (Emergency Medical Services) after falling out of her bed and has had right leg pain, radiographs were obtained that demonstrated a right femur (leg) fracture." The records further document, "(R2) was admitted under the care of the geriatric trauma team."

Post Fall Evaluation Findings for R2, authored by V2, DON, documents the CNA (V3) "was assisting and setting up (R2) on side of bed prior to going out for appointment. (R2) lost her balance and started to slip off the bed (has an air mattress). (R2) landed on her right knee." The findings further document R2 was lifted back to bed using a full mechanical lift and results of the portable x-ray revealed a possible right femur fracture and orders were received to send R2 to the ER for evaluation and treatment.

R2's X-ray report, dated 7/26/19, documents, "A total right knee replacement is noted. A complete fracture through the distal femur (leg) is identified with lateral displacement of the distal fracture fragment."

The facility's policy entitled "USING A TOTAL BODY LIFT TO LIFT FALLEN RESIDENT OFF FLOOR," documents, 1. Once resident has been assessed by nurse and is approved to be moved,

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S9999	Continued From page 4 resident can be moved to a supporting surface. The policy did not address transferring a resident if suspected of a fracture. (B)	S9999		