STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012470	A. BUILDING: _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PITTSFIELD MANOR	610 LOWRY STREET PITTSFIELD, IL 62363

(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	Final Observations Statement of Licensure Violation: 1 of 1 Violation 300.610a) 300.1210b)5) 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 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	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012470	A. BUILDING: _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PITTSFIELD MANOR	610 LOWRY STREET PITTSFIELD, IL 62363

(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 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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. (A, B) (Section 2-107 of the Act) This Requirement is not met as evidenced by: Based on observation, record review and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012470	A. BUILDING: _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PITTSFIELD MANOR	610 LOWRY STREET PITTSFIELD, IL 62363

(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	S9999		

interview, the facility failed to provide supervision to prevent falling for 1 of 6 residents (R2) reviewed for falls in the sample of 6. This failure resulted in R2 falling, hitting her head and being sent to the Emergency Room (ER). R2 sustained a traumatic skull fracture, subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain) and subdural hematoma (a pool of blood between the brain and its outermost covering) that caused her death.

Finding includes:

On 02/02/19, R2 was admitted to the facility with the following diagnoses: Alzheimer's Disease, unsteadiness on feet, history of falls, anxiety and benign paroxysmal vertigo (dizziness and sensation of spinning with certain head movements).

R2's Minimum Data Set (MDS), dated 5/7/19, documented R2 had a Brief Interview of Mental Status (BIMS) score of 4, indicating she had severe cognitive impairment. R2's MDS documented her balance was not steady when walking and when turning around. The MDS documented R2 required supervision of one person for transfers and ambulation.

The Care Plan, dated 05/13/19, documented R2 was at risk for falls with interventions to assist to activities and remind and encourage to call for assistance before getting out of bed or transferring.

On 02/02/19, a John's Hopkins Fall Risk Assessment Tool was documented upon R2's admission. It documented R2 was assessed at a high risk for falls due to age being greater than 80

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012470	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PITTSFIELD MANOR	610 LOWRY STREET PITTSFIELD, IL 62363

(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		

years, having fallen within the last six months, currently taking two or more high fall risk drugs and behaviors of being impulsive. On 06/26/19, the John's Hopkins Fall Risk Assessment Tool assessed R2 being no fall risk due to being unresponsive.

On 03/07/19, R2's Accident and Incident Report documented R2 fell in the hallway while ambulating independently attempted to sit down in a chair and fell face first onto floor. R2 sustained an abrasion to bridge of her nose.

On 03/08/19 at 2:43 AM, R2's Progress documented "Reminded to use call light for staff assist."

On 04/26/19 at 12:08 PM, an Accident and Incident Report documented R2 fell in the dining room while attempting to sit down.
R2's Accident and Incident Report, dated 05/13/19 at 4:27 AM, documented R2 reported she had fallen out of bed sustaining 0.3 centimeters (cm) scrape on right elbow, 4 cm raised, bruised area behind right ear, pinpoint area to right ear lobe and 3 cm raised area in front of right ear. It documented R2 was sent to the emergency room with negative CAT Scan report and was sent back to the facility. The physician ordered to monitor for any changes.

R2's Accident and Incident Report, dated 5/20/19 at 6:30 PM, documented R2 reported falling in the last two days. At 9:23 PM, a nurse's note documented "full body assessment was completed with left hip bruise measuring 15 cm x (by) 8 cm, dark purple in color. Resident states that's when I fell and complained of area being sore."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012470	A. BUILDING: _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PITTSFIELD MANOR	610 LOWRY STREET PITTSFIELD, IL 62363

(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		

R2's Nurse's Note, dated 5/21/19 at 2:05 PM, documented R2 complained of dizziness and stated she had fallen one to two days ago. Physician order for labs with dehydration results. On 05/22/19, Physician's Order (PO) dated 5/22/19, documented "intravenous fluids and left hip x-ray." The left hip x-ray was negative for fracture.

On 06/14/19, R2's Nurse's Note documented R2 had "kneeled self to the floor stating she was dizzy."

On 06/24/19 at 9:15 AM, R2's Nurse's Note documented R2 left in facility vehicle for dental appointment. At 10:33 AM, a nurse's note documented V4, Certified Nurse's Aide (CNA) and facility bus driver called and reported R2 had fallen while at the dentist and was sent to the emergency room via ambulance. At 12:38 PM, a nurse's note documented the hospital called regarding R2 with a diagnosis of "brain bleed."

On 07/19/19 at 11:15 AM, an Accident and Incident Report log was presented and the 06/24/19 incident was not listed on the June 2019 log. On 08/02/19 at 10:20 AM, a revised Accident and Incident Report for June 2019 was presented by the V2, Director of Nursing. V2 stated the facility had failed to report this and do an investigation. V2 stated the incident involving R2 had happened outside the facility and was not aware that the log had not been updated and an official investigation had not been completed.

R2's Hospital Computed Tomography (CT) scan, dated 6/24/19, documented "There is acute intracranial hemorrhage and a complex skull fracture which extends across the skull from right to left."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012470	A. BUILDING: _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PITTSFIELD MANOR	610 LOWRY STREET PITTSFIELD, IL 62363

(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		

R2's Hospital History and Physician (H&P), dated 6/24/19, documented the CT scan showed an extensive subarachnoid hemorrhage, subdural hemorrhage and complex skull fracture. The H&P documented the family was notified of the findings and documented "They have agreed to keep patient in the hospital with comfort measures only, with the understanding that patient will likely soon pass related to the intracerebral hemorrhage."

R2's State of Illinois Certificate of Death Worksheet, dated 7/9/19, documented R2 expired on 6/27/19. The cause of death documented "blunt force trauma" due to "falling and striking head on ground."

On 08/07/19 at 3:20 PM, V5, CNA stated he had worked on the locked unit for years and remembered working with R2. He stated R2 was at first mostly independent with needing only cues during care or direction to activities or meals. He stated toward the end before R2's death, R2 required more cueing and assistance with care and more supervision. He stated she wandered throughout the unit without assist mostly but did have to have hand holding assistance while walking at times and did not know how to use her call light for assistance. He stated R2 complained of dizziness at times, especially during showers which was twice weekly. He stated he would not leave R2 unattended outside.

On 08/07/19 at 3:30 PM, V6, CNA stated R2 was at first independent with cueing from staff. She stated R2 was unable to use her call light or remember what it was for. She stated just before her death, R2 needed more assistance with care, was incontinent at times, required more

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012470	A. BUILDING: _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PITTSFIELD MANOR	610 LOWRY STREET PITTSFIELD, IL 62363

(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		

assistance with ambulating (hand holding) and complained more often of headaches and dizziness. V6 stated R2 needed extra hygiene assistance with toileting and would frequently take herself to the bathroom unassisted.

On 08/07/19 at 4:05 PM, V4, CNA/Facility Transportation Driver, stated she had transported R2 to the dentist on 06/24/19 and witnessed her fall. V4 stated she arrived at work that morning and was informed that R2 needed to be transported to the dentist. She stated R2 was taken via wheelchair by V8, CNA from the locked unit to the front entrance to the facility and then ambulated without a gait belt to the van with assisting R2 by grasping R2's hand to help keep her balance as she stepped into the bus and buckled her seatbelt. V4 described the van as having a double door in which R2 could step down onto the roadway next to the sidewalk of the dentist's office. When they arrived at the dentist office, the front entrance was not available, so she had to park parallel to the building. She opened the side double doors, assisted R2 with unbuckling seatbelt and with grasping R2's hand to assist step down the step of the van to the edge of the sidewalk. V4 then stated she continued to hold R2's hand while assisting her up two steps to the sidewalk and then turned to close the double doors and around the back to the driver's side door to park the van when she said she saw R2 fall to the ground through the van window. V4 described the van as having full windows on each side, double doors on the right side with a chair lift, an emergency door at the end and a driver's side and passenger side doors. She stated she immediately ran to R2 who was attempting to sit up and saw that her head was bleeding. She stated she called 911 because she knew the injury to the head was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012470	A. BUILDING: _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PITTSFIELD MANOR	610 LOWRY STREET PITTSFIELD, IL 62363

(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		

enough to go to the emergency department. She went to turn off the van and put on gloves and held pressure to R2's head. She stated she was not sure if R2 had hit her head on the van or the concrete. She stated the county sheriff arrived, then the ambulance and R2's daughter. She stated R2 was confused and not making sense. V4 stated she did not know R2 had a history of falls or wandering or needing stand by or limited assist. V4 stated V8, CNA told her R2 could walk to the van, but needed help with the steps and seatbelt. She stated this was the first time she had transported R2.

On 08/07/19 at 11:01 AM, V3, R2's Physician, stated R2's condition upon admission to the facility was guarded due to advanced end stage Alzheimer's Disease resulting in debility and decline in mental and physical abilities. He stated the admission was after a lengthy period where the family was caring for R2. He stated R2 was admitted due to increased debility, weakness, falling, wandering and eloping from home. He stated R2 was alert to self only and was not be able to remember simple directions and had poor safety awareness. He stated R2 was ambulatory, but at times not steady due to physical decline and dizziness and did require staff supervision. He stated R2 had fallen at home and the facility several times with some injuries, mostly skin tears, bruising and abrasions. He stated that the fall on 06/24/19 certainly contributed to R2's death due to skull fracture with brain hemorrhage. He stated he had been told that R2 had fallen in the community at a dentist appointment and was left unattended while the facility van driver was parking the van.

On 08/07/19 at 6:15 PM, V1, Administrator, stated the facility did not have a specific policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012470	A. BUILDING: _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PITTSFIELD MANOR	610 LOWRY STREET PITTSFIELD, IL 62363

(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 and procedure on transporting residents regarding resident's special needs, history of falls or whether direct physical contact during assist was required. On 08/12/19 at 12:35 PM, V9, Registered Nurse (RN), stated she was working on 06/24/19 and recalls telling V4, CNA that R2 should be taken by wheelchair from the unit to the front lobby to get on the van due to it being such a long walk and R2 may become too tired. V9 stated she did not specifically tell V4 of R2's falls history, dizziness or transfer requirements. On 08/12/19 at 2:00 PM, V1, stated the facility does not have a specific policy and procedure regarding how staff notify facility van drivers transporting residents of their required needs for 1-2 staff during transport, wandering residents or special needs during transport. V1 stated that staff rely on nursing assessments and the John's Hopkins Fall Risk Assessment Tool for ADL care and assistance needs for each resident. (A)	S9999		