Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009443	A. BUILDING: _____ B. WING _____	C 10/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRI-STATE VILLAGE NRSG & RHB	2500 EAST 175TH STREET LANSING, IL 60438

(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 Investigation # 1997311/IL 116334	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 d)6) 300.3240 a) 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. 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 are not met as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

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Based on interviews and record review, the facility failed to supervise R1 during personal care to prevent a fall, and failed to follow the MDS (Minimum Data Set) assessment utilizing a (2) person assist while providing care at the bedside. This failure resulted in R1 being left alone in bed during care and falling to the floor, sustaining an injury to the head. R1 was transferred to the local hospital and diagnosed with a laceration to the head, requiring (6) sutures.

Findings Include:

R1 is 82 years old, admitted to the facility on 08/19/18. BIMS (Brief Mental Status) was 7/15. R1 is not able to make needs known and is totally dependent, requiring a 2+ person assist from staff for all ADLs (Activities of Daily Living).

Diagnosis: Hemiplegia (Left side- LE), Hemiparesis following unspecified Cerebrovascular Disease affecting left non-dominant side, Unspecified Dementia with Behavioral disturbance, Type 2 Diabetes Mellitus without complications, Muscle weakness (generalized), Altered Mental Status, unspecified, Abnormal weight loss, Cognitive Communication deficit, Dysphagia, unspecified, CVA with Left Hemiparesis

Hospital Record: September 27, 2019 at 3:39 pm
- Seen in Emergency Department
Chief Complaint - FALL,
Your Diagnosis - Head Injury, A Fall requiring 6 sutures

Facility Incident Report: Initial and Final report faxed to Illinois Department of Public Health (IDPH).

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Initial Incident Report: 09/27/19 at 1:35 pm, R1 noted on floor with open area to left side of forehead. Pain assessed, PRN pain medication given. R1 was sent to the Emergency room (ER) for further evaluation.

Final Incident Report: 10/04/19 at 7:22 pm, Interviews were conducted per investigation, E1 is identified as V6 (Certified Nursing Assistant - CNA) for this investigation was questioned about the fall. V6 stated that while care was being rendered to R1, V6 walked away to the sink, at that time R1 was in the center of the bed with the bed in lowest position. V6 stated while V6 was at the sink for a short period of time, R1 rolled out the bed.

E2 identified as V8 (Nurse) for this investigation: When I was called to R1's room, R1 was noted on the floor and I began to assess R1. (R1) was sent to the hospital and returned with (6) stitches to the forehead, orders in place and being carried out.

Review of Annual MDS dated - July 7, 2019, Section G (Functional Status) scored R1 as followed: Self Performance Code (4) =Total Dependence, full staff performance every time during entire 7 day period.

Code (3) = Extensive Assistance, resident involved in activity, staff provide weight-bearing support
ADL Support Provided, R1 scored a 3 = Two + person physical assist. Bed Mobility = 3/3, Transfer = 3/3, Dressing = 3/3, Toilet Use = 3/3, Personal Hygiene = 3/2, Bathing= 4/3

Review of Quarterly MDS dated 10/01/19 = Bed Mobility = 3/3, Transfer = 3/3, Dressing = 4/3,

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Toilet Use = 3/3, Personal Hygiene = 4/2, Bathing= 4/3.

Review of Care Plan revised on 07/09/19 and 10/08/19 - R1 is at risk for falls, R1 has a transfer/mobility impairment related to CVA with Hemiparesis. Muscle weakness and impaired balance. Transfer - Mechanical Lift, dependent on two person staff assist. R1 is dependent on staff for Most ADL care.

Review of Personal Care Chart for Resident (R1) - Transfers = Dependent x 2 Staff, Dressing, Toileting, Bed Mobility, Grooming and Bathing are all marked as Total Assist x 2 staff.

During a face to face interview with V6 (CNA) on 10/22/19 at 2:15 pm, Surveyor asked V6 what happened on 7/9/19 that caused R1 to fall out of bed, sustaining an injury to the head. V6 said, "Myself and another CNA (V7) helped me transfer my resident R1 to bed. V7 left the room to take care of V7's own residents. I was giving R1 care, I went over to the sink and before I could turn around good, R1 had fallen to the floor. I was at the sink trying to clean R1 up. I called for the nurse to come, V8 (nurse) came into the room to assess R1." Surveyor asked V6 if she was the only one in the room at the time V6 fell out of the bed onto the floor. V6 stated, "Yes I was the only one when it happened."

Two phone attempts were made to speak with V7 (CNA) on 10/22/19 at 2:20 pm and 2:50 pm; surveyor left voice mail messages; V7 did not return surveyor's call.

During a phone interview with V8 (nurse) on 10/23/19 at 2:20 pm, V8 was asked if V8 was in the room when R1 fell out of bed onto the floor.

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V8 stated "I was called to R1's room, when I arrived R1 was on the floor. V6 was in the room when I arrived, she said she was providing care, she walked over to the sink and R1 fell out of bed. I assessed R1 who was laying on the floor on the left side bleeding from the head. I cleaned and applied steri strips and went to call the doctor." R1 went to the hospital and received 6 sutures to the head.

Review of Progress Note: dated 9/27/19 - Resident rolled out of bed looking for staff member whom had stepped to the sink to moisten towel for patient care, resulting in a laceration to the left side of forehead, with moderate bleeding, pressure applied, steri strips. Paramedics called for transfer to the local Emergency room for evaluation, family notified.

Physician Interview: Two telephone attempts were made to contact V4 (Physician), messages were left with no return call back.

Facility's Policy: Falls Clinical Protocol was reviewed, "# 5. Staff will document risk factors for falling and document when and where it happened, any observations of the event."

On 10/29/19 at 11:00 am, during a face to face interview with V1 (Administrator), surveyor asked V1 for a policy and procedure related to fall prevention, not a post fall policy. V1 stated the policy given was the only fall policy they had.

(B)