STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003644	A. BUILDING: _____ B. WING _____	C 10/24/2019

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S 000	Initial Comments Annual Certification Survey Complaint Investigations 1952206/IL110757	S 000		
S9999	Final Observations Licensure Violations 300. 610(a) 300.1210 b) 300.1210d)6) 300.1220b) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to have care plan interventions in place to address a resident's impulsive behavior to stand or self- transfer without assistance and individual	S9999		

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S9999	Continued From page 2 plan for monitoring and supervising the resident to prevent a fall. This has the potential to affect one of six residents (R286B) reviewed for falls. This failure resulted in R286B having a fall, sustaining a subdural hematoma and subsequently died 12 days later. Findings include: R286B was an 88 year old resident with diagnoses including dementia and was assessed to be at a high risk for falls. Incident report dated 1/11/19 at 2:40 pm stated, Resident suddenly stood up from her wheelchair and fell backwards. Sustained a bump at the back of her head. No loss of consciousness noted. Resident was transferred to the hospital for evaluation. Complete body assessment done. Family notified. It has been confirmed that R286B will be admitted for subdural hematoma. Resident is alert, oriented x1. Resident stood up from her wheelchair and was unable to maintain a steady balance falling backwards resulting in bump to her head. Resident returned to the facility on 1/12/19 with no medical intervention of the subdural hematoma. On 1/10/2019, an incident note written by V12 (Licensed Practical Nurse) stated, around 2:40 pm, resident was sitting in the dining room when she suddenly got up from her wheelchair and fell backwards. Staff could not get to her fast enough to catch her. Resident said she wants to go back to her room. Complete body assessment done. Noted bump on back of her head. She is able to move all extremities within her normal limits. Neuro check initiated no loss of consciousness noted. Resident not able to describe pain but was holding back of her head. Ice pack applied to	S9999		

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S9999	Continued From page 3 back of head immediately. MD notified. Will transfer resident to hospital for CT scan (special x-ray). Family notified. On 1/11/2019, a following nursing progress note read, resident admitted to hospital with diagnosis of intracranial bleeding. On 1/22/2019, V12 wrote, at 7am, received resident in bed, lethargic, vital signs taken, called and informed doctor of residents condition change. Resident unable to swallow food and medications. 12:35pm resident expired confirmed with 2 registered nurses. Notified family and doctor. V12 on 10/22/19 at 2:28 pm stated, "I was by the large dining room by the door and I saw her (R286B) sitting down. I was not passing medications, but I don't remember what I was doing. I saw her getting up and fall like this. (V12 motioned that resident fell forward from her sitting opposition). I was trying to catch her." Surveyor asked if there were any other staff in the dining room, V12 stated, "No, I don't think so." V12 showed surveyor where she was standing and where R286B was seated and fell in the dining room. According to V12, R286B was on the left hand side near the center of the dining room area and she (V12) was outside of the threshold to the dining room. Asked to clarify if there was another staff person in the room, V12 stated, "I don't think there was any staff or CNA (certified nurse's aide) there." V2 (Director of Nursing) on 10/22/19 stated, "I interviewed the nurse (V12) to investigate the fall and viewed the video footage in the dining room. There were other residents in the room and the video confirms no staff were present in the dining room." R286B was hospitalized on 10/03/18 with a	S9999		

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S9999	Continued From page 4 diagnosis including UTI (urinary tract infection) and returned to the facility on 10/06/18. Fall Risk Review (dated 10/06/18), Upon readmission R286B was assessed as "a high risk for falls." Prior facility fall risk assessments for R286B dated 11/26/18, 10/6/18, 10/27/18 show R286B was at risk at high risk for falls and showed a history of falling. Physician Progress Note dated 10/15/18 10:55 documents, "6. Risk of fall - follow fall precautions protocol. Patient is at high risk of fall secondary to ataxia, muscle weakness, poor cognition and safety awareness, poor balance and neuropathy." V17 (Physician) on 10/23/19 at 1:42 PM stated, "They should have been watching her(R286B) and not left her alone. I remember she was confused so they could have been doing 1:1 with her too but should not be by herself. I remember signing the death certificate." Asked what other interventions should have been in place to prevent R286B from falling, V17 stated, "You should ask them (facility). If she had history of fall already, she needed to be monitored and if nobody was in dining room, that's not good." R286B "Fall Risk Care Plan (last update 1/10/19) includes (but not limited to) the following problem statements: History of Falls, Decreased Safety Awareness, Impulsiveness with attempts to Stand or self-transfer without Assistance from the staff, and Leaning forward in chair with Attempts to pick up objects. Approaches/Interventions include: Gather information on past falls and attempt to determine cause of falls. Anticipate and intervene to prevent future recurrence; Be sure call light is within reach and encourage to use it for assistance as needed. Respond promptly to all requests for assistance; Anticipate and meet	S9999		

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S9999	Continued From page 5	S9999		

needs; Complete Fall Risk Assessment per facility protocol; (added date 01/10/19) Neuro check until transfer to hospital; Refer to therapy upon return; Staff to assist resident to bed around 2pm; and Toilet resident before assisting to bed.

On 10/24/19 at 12:45pm V2 (Director of Nursing) stated, "R286B would constantly try to get up from bed and chair without calling for help and that staff were expected to check on the resident hourly." V2 acknowledged that this was not documented in the care plan and that there was no specific intervention in the care plan to address the resident's impulsiveness, other than for staff to check on her constantly (which was not documented). V2 also stated that the resident's care plan interventions had not been updated since 6/11/18, except for History of Falls being added to the Problem Statement and the (4) interventions that were added on 01/10/19 after the resident's fall. According to V2, the care plan interventions were not updated after the resident came back from the hospital with a noted fall in October 2018. The dates listed under goals/objectives only indicate the dates that the care plan quarterly review was conducted.

Death certificate shows R286B died on January 22, 2019 in the facility with cause of death listed as "Subdural Hematoma due to (or as a consequence of) Fall."

Facility provided "Fall Prevention and Management" policy dated 08/03/17 includes: "2. Approaches/interventions should focus on risk factors identified" and "Evaluation of the interventions is completed 1. Quarterly, 2. Post fall, and 3. Interventions are modified as indicated based upon evaluated efficacy of the interventions."

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S9999	Continued From page 6 Facility's undated policy and procedures for falls titled "Fall Prevention Protocol" states, "Residents who are assessed at high risk for falls, have had multiple falls or have had a significant fall within the last six months may be included in the fall program as determined by the interdisciplinary team. Residents on the program may be observed every two hours or as determined by the interdisciplinary team; this should include all levels of staff. If resident is observed in unsafe action that could lead to falls, staff shall intervene immediately. Interdisciplinary care plan is implemented for residents at risk and may include interventions to prevent falls, physical and or occupational therapy screen and training, assistive devices as appropriate, supervision as appropriate." (B)	S9999		