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
	IL6005979	A. BUILDING: ______ B. WING ______	C 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP SKILLED NSG & REHAB	826 NORTH HIGH CARLINVILLE, IL 62626

(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 1841439/IL100783	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999	Attachment A Statement of Licensure Violations	

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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. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to provide supervision to prevent falls for 2 of 3 residents (R1 and R2) of 3 reviewed for falls in the sample of 6. This failure resulted in R1 falling and receiving multiple facial fractures and a subdural hemorrhage. R2 fell and received a laceration requiring 7 sutures to close the wound.

Findings include:

1. R1's MDS dated 1/25/17 documented that R1 required extensive assistance and two plus physical assistance for bed mobility, transfers, and toileting.

R1's Fall Risk Assessment dated 7/11/17 documented a score of 55, with a score of 45 or higher indicating a high risk for falls. R1's Fall Risk Assessment dated 10/05/17 and 12/07/17 documented a score of 55. R1's Fall Risk Assessment dated 3/5/18 documented a score of 75.

R1's Care Plan dated 4/8/15 documented R1 was at high risk for falls related to paralysis to left side. R1's Care Plan documented R1 had history of falls

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The facility's Fall Report of Incident dated 2/17/17 documented that R1 fell out of R1's wheelchair and received a skin tear to right hand, Left side of face bruising and hematoma to left face and eye.

The Facility Fall Report of Incident dated 2/28/28 at 17:26 PM documented R1 fell out of wheelchair during transport. The report documented R1 received laceration and bruising.

The facility Verification of Incident Investigation/Administrative Summary, dated 2/28/18, documented that R1 was being transferred from bed to wheelchair by a CNA. The Summary documented that R1 was assisting with the transfer by placing R1's feet on the floor. The summary documented once R1 was positioned in the wheelchair the CNA reached down beside the bed to get the wheelchair pedals and R1 was noted to fall to the floor. The summary documented under investigative finding that R1 was alert with confusion and has decreased safety awareness due to a diagnosis of Dementia and has a history of Cerebral Vascular Accident with Left Sided Hemiparesis. It also documented R1 required 2 staff physical assistance with mechanical lift transfer as Needed (PRN).

R1's Cat Scan of Head done at the hospital on 3/1/18 documented under impression: "1. Scattered acute subarachnoid hemorrhage, most pronounced in the frontal regions, slightly increased since prior exam one day earlier. 2. New small acute intraventricular hemorrhage. 3. There may be a small acute subdural hematoma along the right tentorial leaflet. 4. Redemonstration of acute left orbital/maxillofacial fractures."

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S9999	Continued From page 3 On 3/12/18 at 1:02 PM, V2, Director of Nurse's, when asked by surveyor if MDS documented 2 plus physical assistance for transfers, would that be the staff expectation to transfer R1. V2 responded "yes." The Facility's Fall Management Procedure dated August 2014 documents in part the facility will evaluate risk factors and provide interventions to minimize risk, injury and occurrences. The facility will initiate a fall prevention are plan when appropriate with strategies to minimize risk and potential for injuries. Review, revise and evaluate care plan effectiveness at minimizing falls and injuries. 2. R2's Physician's Orders (PO) dated 3/2018 documented R2's partial diagnoses as Hemiplegia and Hemiparesis following a Cerebral Infarction affecting Left Non-Dominant side. R2's Care Plan dated 2/16/18 documented R2 had a self care deficit as evidenced by: Needs extensive assistance with Activities of Daily Living (ADL) related to recent stroke and weakness. R2's Care Plan lists intervention: two person physical assistance required for toileting. R2's Care Plan documented R2 was at risk for fall and injuries related to poor cognition, recent stroke and weakness. Interventions listed were to assess R2's toileting needs, encourage use of call light and low bed. R2's admission Fall Risk Assessment dated 2/26/18 documented a score of 60, with a score of 45 or higher indicating a high risk for falls. R2's Minimum Data Set (MDS) dated 2/23/18 documented R2 required extensive assistance	S9999		

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and two plus physical assistance for transfers and toileting. R2's MDS documented that R2 had functional limitation in range of motion on one side of both the upper and lower extremity.

R2's Progress Notes Late Entry for 3/2/18 10:20 A.M., documented resident fall reported. Resident in stable condition. POA (Power of Attorney) aware. POA arrived at 11:15 A.M. requesting resident be sent to Emergency Room (ER). Transport arranged. Resident sent to ER at 12:01 PM.

R2's Verification of Incident Investigation/Administrative Summary, signed and dated by V2, Director of Nurse's (DON) on 3/2/18, documented "Resident lost balance while sitting on toilet and fell onto floor." The Summary documented "Res (Resident) was escorted back from therapy stating she needed to go to the toilet. Res was assisted per 2 staff assist and gait belt onto toilet in shower room. Res stated to CNA (Certified Nurse's Aide) that she need to have a bowel movement but couldn't get it to 'come out.' CNA stepped to door that was feet from toilet where resident was sitting. CNA stated she opened the bathroom door just a fraction to maintain privacy to tell nurse resident had request a laxative. In turning around, res was noted to have lost balance and fell onto bathroom floor." The Summary documented she sustained a laceration to her left forehead.

On 3/8/18 at 10:00 AM, V5, Emergency Room Physician stated R2 was brought to the emergency room with a head laceration. V5 stated she closed the wound with 7 sutures. V5 stated that R2 stated she had been left in the toilet. V5 Physician stated that R2 recently had a stroke and has Left side Hemiplegia and should

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S9999	Continued From page 5 never be left alone on the toilet. V5 stated this fall and injury could have been prevented had staff not left R2 alone in the bathroom. On 3/8/18 at 10:55 AM, V4, Licensed Practical Nurse (LPN) stated that R2 required assistance with bed mobility, transfers and toileting. When asked by surveyor if R2 could be left alone on toilet safely, V4 stated "I wouldn't." (A)	S9999		