STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014955	A. BUILDING: _____ B. WING _____	C 04/05/2018

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S 000	Initial Comments Complaint Investigation #: 1871981/IL101369	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999	Attachment A Statement of Licensure Violations	

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and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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:

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.

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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 evidence by:

Based on record review, observation and interviews the facility failed to supervise residents at increased risk for falls, failed to avoid resident falls and failed to revise interventions to prevent further falls when necessary. As the result of these failure:
R1 was transferred to the hospital after an unwitnessed fall, R1 returned from the hospital three hours later with a diagnosis of closed fracture right shoulder and contusion, on February 25, 2018 R2's fall resulted in scraping R2's knee and R3 fell and was diagnosed with a hip fracture needing surgical repair and hospitalization.

This applies to 3 of 3 residents (R1, R2 and R3) reviewed for falls in the sample of 12.

The findings include:

1) R3 was admitted to the facility on January 20, 2018 with diagnoses that included History of Falls, Muscle Weakness, Difficulty Walking and Left Femur Fracture. R3's Nursing Fall Risk Admission Data Collection, dated January 20, 2018 documented the resident didn't have a history of falls, scored R3 as at risk for falls and recommended initiation of fall risk interventions. R3's BIMS of February 16, 2018 scored the resident at "3" indicating severe cognitive impairment. Bed mobility and toilet use scored

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the resident as in need of extensive assistance of two or more persons. R3 was also assessed as non ambulatory. Facility incident report of February 6, 2018, documents that R3 was found at 3:00PM in R3's room on the floor with pain to the left hip. According to the facility incident report, R3 was admitted to the local hospital for surgical repair of the left hip after falling in R3 room. The radiology report dated February 6, 2018 denotes an acute left hip fracture.

On January 20, 2018 a care plan for R3 was initiated that addressed the resident's impaired cognitive function/dementia or impaired thought processes due to dementia. The fall care plan for R3 wasn't initiated until February 7, 2018 after the resident fell and fractured R3's femur. Fall prevention interventions listed included encouraging the resident to wear non skid footwear when ambulating or mobilizing in wheelchair, encourage resident to use call light. R3 is confused and unable to follow staff instructions on use of call lights, is unable to understand being encouraged to participate in activities.

On March 30, 2018 between 2:05 PM and 3:45 PM V3 stated before R3 broke R3's hip R3 didn't walk well, wasn't oriented and couldn't remember instructions. V3 said R3 required hands on help and lots of coaching to walk due to believing R3 is independent. On the day R3 fell physical therapy had brought R3 back to the room and didn't inform staff.

On April 3, 2018 at 3:50 PM V10 (nurse) described R3 as very confused and with difficulty processing information. R3's fall where R3 fractured R3's hip happened in R3's room at 2:30 PM. R3 was found laying face down and

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complained of leg pain, was sent to the hospital and determined to have a hip fracture.

2) R1's facility record showed R1 was admitted to the facility October 19, 2017 with diagnoses including Cerebral Infarct, muscle weakness, gait and mobility abnormality. R1's 14 day Minimum Data Set (MDS) dated November 1, 2017 , under the Brief Interview for Mental Status (BIMS) scored the resident as having some difficulty with cognition. The MDS also assessed the resident as in need of extensive assistance of two persons to transfer and as unable to balance (R1) when walking and transferring without staff help. R1's Admission Data for Fall Risk dated October 19, 2017 scored the resident as a fall risk and instructed fall risk interventions to be initiated and documented on the interim care plan. R1 had a fall October 24, 2017.

Review of R1's Physical Therapy Evaluation of October 20, 2017 assessed the resident as having deficits in gait, transfers and bed mobility skills, impairments in strength and also showed R1 had impaired cognition, visual and perceptual deficits and decreased proprioception that impacted his safety and independence..."the patient is at risk for falls".

R1's care plan, initiated October 19, 2017 assessed the resident as a fall risk. The facility failed to implement interventions to prevent falls until R1's fall on October 24, 2017 and didn't update and or revise the resident's care plan until after the fall on November 11, 2017. The facility also failed to consider the resident's previously identified confusion when interventions such as encouraging R1 to use the call light for assistance and encouraging the resident to participate in activities and providing cues and supervision as

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indicated were put into place.

The October 24, 2017 Incident Report for R1 at 1:30 PM documented R1 fell in R1's room and was witnessed by R1's roommate but was not witnessed by staff. According to the Incident Report the resident was observed on the floor and said (R1) had been trying to go find help. No injury was noted. The only documentation of R1's fall on October 24, 2017 was at 8:46 PM in the Progress Notes.. Note of October 25, 2017 mentions a low bed and staff encouraging R1 to ask for help and to lock the wheel chair. The call light was placed within reach.

On November 7, 2017 R1 is documented as having told R1's family that R1 had fallen that morning and told staff R1 falls daily. Staff assessed the resident at that time, but found no injury.

On November 11, 2018 at 11:55 AM R1 had another unwitnessed fall in R1's room. The Incident Report for R1 stated (R1 had) fallen when R1 reached for the door handle and lost R1's balance and fell backwards. R1 was observed guarding R1's right arm, complaining of pain in the area and not being able to move R1's right arm. R1 also had a bruise on R1's left lower back . R1 was transferred to an area hospital.

Progress Note of November 11, 2017 at 12:52 PM documents R1's transfer to the hospital after an unwitnessed fall, but failed to give information on the resident's condition post fall that required R1's transfer to the hospital. R1 returned from the hospital three hours later with a diagnosis of closed fracture right shoulder and contusion and wearing an immobilizer.

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S9999	Continued From page 6 On April 3, 2018 at 11:40 AM V5(Certified Nurse Aide) was interviewed regarding R1. V5 stated R1 could walk with transfer help, R1's walking was unsteady. V5 stated on November 11, 2017 V5 had just returned from lunch and and didn't find R1 on the floor and was unsure which staff did. V5 helped get R1 off the floor and the resident complained of shoulder pain, but didn't say how R1 fell. R1 couldn't remember to call staff even if call light was within reach. V5 was unable to remember which previous fall prevention measures were in place to prevent R1 falling. R1 knew how to unlock R1's own wheelchair and would try to get out of R1's wheelchair and bed. V5 stated V5 knew the fall prevention policy was to help prevent or decrease but wasn't able to remember anything else. 3) R2 was admitted to the facility on August 15, 2017 with diagnoses that included Muscle Weakness, Gait and Mobility Disorder and Dementia. R2's Fall Risk Admission Data Collection coded the resident as high risk for falls as did the other seven Fall Risk Data Collection Forms completed post falls although the Fall Risk Form of March 22, 2018 "History of Falls is incorrect; by March 22, 2018 R2 had many more than one to two falls. A PT evaluation on October 19, 2017 indicated R2 had impairments in strength activity tolerance and balance that "contributed to increased difficulty with bed mobility, transfers and gait" and also assessed R2 as needing "constant multiple cueing to complete tasks safely. PT staff assessed "due to the documented physical impairments and associated functional deficits, the patient is at risk for: falls". R2's MDS of November 17, 2017 and February	S9999		

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S9999	Continued From page 7 17, 2018 assessed the resident as having BIMS scores of 14 and 13. Both MDSs assessed R2 as in need of extensive assistance of 2 persons in bed mobility and both assessed R2 as having unsteady balance without staff help. R2 has had eight falls (December 5, 2017, January 19, 2018, February 4, 25 and 27, 2018, March 18, 22 and 24, 2018) that occurred at various times of the day. Seven of the eight falls were unwitnessed, only the fall on March 24, 2018 was witnessed when R2 fell in the hall. The incident report of the fall on February 25, 2018 documented the fall resulted in R2 scraping R2's knee when R2 fell. R2's care plan addressing R2's risk for falls wasn't initiated until September 5, 2017 and the last revision was March 28, 2018. The facility failed to update and or revise the resident's care plan after each fall when it became evident the interventions in place at the time of the falls were ineffective and failed to consider the resident's previously identified confusion when interventions such as educating R2 about what to do in case of falls, encouraging the resident to participate in activities and providing cues and supervision as indicated was put into place. On March 28, 2018 at 3:50 PM R2 was observed sitting in a wheelchair. While alert, R2 was very confused and would look at the surveyor, but wasn't able to answer questions. V9 (Visitor) was present and stated R2 falls because R2 can't remember to wait for help no matter how often R2's told to ask for help. R2 locks/unlocks R2's wheel chair R2's self. Staff instructs R2 multiple times to use the call light to ask for help. V9 stated V9 had put signs in R2's room reminding R2 to ask for help before walking.	S9999		

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V3 (Certified Nursing Assistant/CNA) was identified as having cared for R2 on December 5, 2017, January 19, 2018 and March 24, 2018 on the shifts the resident fell. On March 30, 2018 between 2:05 PM and 3:45 PM V3 described R2 as "forgetful and hard headed" and needing extensive assistance to get out of the chair and R2 tries to walk without using R2's walker and will try to transfer on R2's own. V3 stated if a resident is assessed as a fall risk, he or she isn't to be left alone in their room and also said wheelchairs are to be locked when in use. V3 also denied having worked on the days R2 fell.

On March 28, 2018 at 1:00 PM R4 was observed sitting in a wheelchair at the elevator. The chair wasn't locked and R4 was able to propel R4's self. R4 was irritable and stated the staff makes (R4) stay on the floor and won't let (R4) leave. Further interview showed the resident was slightly confused. At 2:20 PM R3, R5, R7 and R9 were observed sitting in wheelchairs at the nursing station. R3, R5, R7 and R9's wheelchairs weren't locked. R3 was confused and not interviewable.

On March 28, 2018 at 9:00 AM V2 (Director of Nurses/DON) admitted having residents who had falls with fractures and later provided a list of residents with falls. R1 and R3's names were listed and identified as having fractures. At 1:55 PM V2 stated care plans are to be updated after each fall as are the fall risk assessments. At 4:45 PM V2 stated new interventions such as urine cultures and culture and sensitivity post fall were put into place to prevent R1 having further falls.

The facility's policy on Fall Prevention states that a resident who scores 10 or higher as a fall risk is to have a care plan to reflect that higher risk for

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S9999	Continued From page 9 falls and approaches identified to limit those falls. Family and residents are to be educated on the fall prevention program and what they can do to prevent falls, residents are to be monitored frequently, residents instructed to use the call light and wait for assistance and the care plan is to be revised as needed. (A)	S9999		