STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003230	A. BUILDING: _____ B. WING _____	C 07/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF MARION	1301 EAST DEYOUNG MARION, IL 62959

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S 000	Initial Comments Complaint Investigation 2155180/IL136251	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)6) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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.

These regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to safely position a resident during a bed linen change for one of three residents (R2) reviewed for falls in the sample of three. This failure resulted in R2 rolling off the bed and sustaining a fractured left hip, and a laceration to the left side of the head requiring 4 staples.

Findings include:

R2's Medical Diagnosis List documented a diagnosis of Hemiplegia and Hemiparesis following a Cerebral Vascular Accident, affecting the left non dominant side.

R2's 06/02/21 Care Plan documented a problem area, "(R2) is at increased risk for falls related to generalized weakness and decreased mobility, with a corresponding goal, "Will have falls/injuries minimized through management of risk factors while maintaining maximum independence/quality of life through next review."

R2's 06/03/21 Minimum Data Set(MDS) documented R2 requires extensive assistance from at least one staff member for bed mobility and transfers and R2 has limited range of motion to the left upper and lower extremities. This MDS

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S9999	Continued From page 2 also documented a Brief Interview for Mental Status Score of 9, indicating R2 has moderate deficits in cognitive functioning. A Nurses Note, dated 7/18/21 at 2:07 am, documented, "This nurse (was) called to residents room by CNA staff. Upon arrival to room resident noted to be laying on floor beside bed on left side. Puddle of blood noted under and around resident head. CNA staff stated that during full bed change that resident rolled off of the side of the bed. Resident complains of pain to head, left shoulder, and left hip. Emergency services called, and resident transported via ambulance to hospital." R2's Emergency Department Physician Documentation, dated 7/18/21, documents in part, "HPI (History of Present Illness) 3:56 (pm) This 89 yrs old white female presents to ED (Emergency Department) via EMS (Emergency Medical Services)- Ground with complaint of Fall injury. Details of fall: the patient fell from a supine position, out of bed. Onset: The symptoms(s)/episode began/occurred just prior to arrival. Associated injuries: The patient sustained left hip, deformity, painful injury, left side of the back of head, laceration 3cm(s).... Laceration: 5:21(pm) Wound repair of 3 cm (1.2in) subcutaneous laceration to left side of the back of head. Distal neuro/vascular/tendon intact. Wound prep: simple cleansing, with chloroprep. Skin closed with 4 staples using staple gun.... Orders: 3:55(pm).. Findings: Comminuted fracture involving the proximal left femur likely at the Trochanter." R2's 07/21/21 Fall Risk Assessment documented a score of 17, indicating R2 is at high risk for falls.	S9999		

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S9999	Continued From page 3 On 07/28/21 at 12:40pm, V4, R2's Power of Attorney, stated on 7/18/21 at about 2:00am, R2 fell out of bed and was sent to the hospital. R2 was diagnosed with a fractured left hip and a laceration to the left side of her head, which required staples. V4 stated she was told by V1, Administrator, the fall occurred as a result of R2 falling asleep on the edge of the bed. V4 stated R2, however, told V4 one of the CNA's (Certified Nursing Assistants) who work on the midnight shift rolled R2 out of bed while she was changing her bed. V4 stated R2 is generally alert with some issues with short term memory. On 07/28/21 at 1:30pm, V1 stated she was unable to provide the Surveyor with R2's Fall Investigation, as it is considered an internal quality assurance document. On 07/29/21 at 8:40am,V2, Director of Nursing, was interviewed about the findings of the fall investigation. V2 stated R2 is at high risk for falls, and has a history of falls. V2 stated V3, CNA, was the staff member who was with R2 at the time of the fall. V2 stated V3 was by herself in R2's room changing R2's bed after an incontinence episode, and the fall investigation concluded R2 had rolled herself off the edge of the bed. V2 stated the root cause analysis of the fall was determined to be that R2 had decreased safety awareness, and as a result a quarter enabler rail was added to R2's bed as an intervention. On 07/29/21 at 9:05am, R2 was observed in her room lying in bed. R2's bed was noted to have a quarter enabler rail to the right side of the bed. R2 was alert and oriented to time, able to state her name and date of birth, and knew she was in a nursing facility but could not give the name of the facility. R2 had staples to her left forehead, as	S9999		

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well as a surgical dressing to her left hip. R2 stated she "was rolled out of bed" about two weeks ago and fractured her left hip. R2 stated she asked a midnight shift CNA, whose name she does not know, to reposition her in bed. She stated the CNA rolled her too close to the edge of the bed, and she then rolled off the bed and onto the floor. R2 was tearful, and stated she is now in constant pain and requires round the clock pain medication, which is making her constipated. R2 stated, "I'm miserable now. I wish I would have just died instead of having to go through this."

On 07/29/21 at 10:20am, V3 stated she was working the midnight shift on R2's hall on 07/18/21. V3 stated the other CNA working with her that morning was on break when she went in to check on R2 around 2am. V3 stated R2 was awake, and she had been incontinent of urine and the bed was soaked, necessitating a complete change of bed linens. V3 stated she was under the impression R2 only required the assistance of one staff for transfers and positioning. V3 stated she cleaned R2, changed her gown, and was in the process of changing the bottom sheet when she rolled R2 to the edge of the bed, with R2 lying on her right side. V3 stated the bed was approximately two and a half to three feet off the floor, and there were no siderails on the bed as R2 did not have siderails as an intervention. V3 stated R2 did not have a floor mat as a fall intervention, so there was no floor mat in place. V3 stated she positioned herself on the opposite side of the bed to pull the bottom sheet into place. V3 stated she was gently pulling the corner of the bottom sheet over the mattress, when R2 "must have hunched her shoulder or something, and she rolled off the bed and onto the floor." V3 stated she yelled for nurse, and applied pressure to R2's head which was

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S9999	Continued From page 5 bleeding. V3 stated after the fall, she was re-educated by management that R2 was to always have the assistance of two staff for transfers and positioning. On 7/29/21 at 11:15am, V2 acknowledged V3 should have had another staff member present on the opposite side of the bed since R2 was positioned at the edge of the bed. V2 stated he educated V3 to have another staff with her on the opposite side of the bed if a resident was to be rolled to the edge of the bed, regardless of the amount of staff required for transfers and positioning. On 07/30/21 at 9:20am, V1 stated when she discussed R2's fall with V4, she told V4 a staff member had been changing R2's bed when R2 rolled off the bed. V1 stated she did not tell V4 R2 rolled off the edge of the bed while she was sleeping. A Fall Management Policy, with a review date of 2019, documented, "It is the policy of the facility to have a fall prevention program to assure the safety of all resident(s) in the facility when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary...Safety interventions will be implemented for each resident identified at risk using a standard protocol....Facility staff are responsible for assuring ongoing precautions are put in place and consistently maintained." (A)	S9999		