STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001044	A. BUILDING: _____ B. WING _____	C 09/02/2021

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LEBANON CARE CENTER	1201 NORTH ALTON LEBANON, IL 62254

(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: 2145990/IL137225	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 4) 300.1210 b) 5) 300.1210 d) 2) 300.1210 d) 3) 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. This REQUIREMENT is not met as evidenced by:	S9999		

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S9999	Continued From page 2 I. Based on interview and record review the facility failed to ensure residents receive timely assessment, pain management and medical treatment for a fracture for one of three residents (R2) reviewed for timely treatment of a fracture in the sample of 9. This failure resulted in R2 having at least a 12-hour delay in treatment for a fractured right arm causing her unnecessary pain and inability to participate in therapy. II. Based on interview and record review the facility failed to ensure residents receive adequate supervision to prevent falls for 1 of 3 residents (R2) reviewed for falls in the sample of 9. This failure resulted in R2 having multiple falls and sustaining a 4-centimeter (cm) laceration to her forehead requiring emergency care. Findings include: R2's Physician's Order Sheet (POS), dated August 2021, documented R2 had diagnoses of dementia with agitation, cataracts, A-Fib, CAD, and anxiety. R2's Minimum Data Set (MDS), dated 4/26/21, documented R2 is cognitively impaired. R2's MDS documented she required staff supervision for bed mobility, transfers, walking in room, locomotion on and off the unit and eating. R2's MDS documented she required limited assistance from staff with bathing and dressing. The MDS documented she required extensive assistance of one staff person for toilet use and personal hygiene. R2's MDS documented she was not steady during transitions and walking but was able to stabilize without staff assistance. The MDS documented R2 used a walker.	S9999		

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S9999	Continued From page 3 R2's current, Care Plan, undated documented "(R2) is at risk for falls relating to use of assistive devices, medication use, history of falls diagnosis of osteopenia. Currently (R2) ambulates independently with wheeled walker to destination at a fast pace." R2's Care Plan Goal, dated 3/11/2021, documents "Will have no falls while ambulating thru next review." R2's Interventions, all dated 12/11/2020, document "Review quarterly and as needed during daily care and services of resident's plan for safety, giving verbal cues, as needed to gain resident's participation in minimizing risk factors and injury; (R2) ambulates independently with wheeled walker to destination; Assess cognitive deficits and accommodate forgetfulness regarding safely devices and environmental risks; Inform physician of any falls, including report of injuries. Request physician review of medications and conditions during nursing home visit especially after falls." R2's Nurse's Note, dated 7/22/21 at 5:07 PM, documented R2 had an unwitnessed fall with possible head injury. The Note documented "Refer to fall report for more details." Facility's AIM for Wellness form, dated 7/22/21, documented R2 had a fall with possible head injury. The form documented "Nursing note: (R2) was found on the floor in the looking glass dining room in semi fowlers position guarding the back of her head. (R2) stated I fell and hit my head. No apparent injuries observed. Range of motion and neurological checks within normal limits. (R2) appeared to have been transferring without use of walker. Her physician and family were notified. Tylenol 650 mg (milligrams) was administered for complaint of headache. (R2) was transferred to the local hospital for a head cat scan. The Director of Nurses (DON) was aware." The form	S9999		

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S9999	Continued From page 4 was signed at 8:00 P.M. There is no documentation in R2's medical record the facility reassessed R2's risk for falls and implemented progressive interventions to address R2's fall and to prevent her from future falls. R2's Nurse's Note, dated 7/30/21 at 2:00 PM, documented R2 had a fall around 1:30 PM in hallway and the fall was witnessed by nurse. The Note documented R2's vitals within normal limits and no pain was reported. The Note documented R2 did not hit her head. The Note documented Nurse Practitioner (NP) notified and ordered neuro checks per facility protocol. Notified family and DON (Director of Nurse's) of fall. Facility's AIM for wellness form, dated 7/30/21, documented R2 fell when walking with walker. The form documented neuro checks were ordered. The Functional status evaluation documents "Falls (more than one), NP (Nurse Practitioner) and family notified (R2) fell with walker just went down did not hit her head. Vitals good. Walked to room with walker." The Form's Nursing note documented "Fall in hallway walking with walker, just went slowly down, did not hit her head. (R2) talking after fall wanting to get up. Assist of one and walker to stand. (R2) walked to her room. Notified NP and family. New orders for neuro checks per facility protocol." The form was signed at 2:00 PM. There is no documentation in R2's medical record the facility reassessed R2 for falls and implemented progressive interventions to address R2's fall and to prevent her from future falls.	S9999		

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S9999	Continued From page 5 R2's Nurse's Note dated 7/31/21 at 6:40 AM, documented "Sent res to ER (Emergency Room) due to bump to back right side of head for evaluation" sent to local hospital. (R2's) family and DON notified. Left message to call. Administrator notified of resident going to ER." R2's Nurse's Note dated 7/31/21 at 11:30 A.M. documented R2 was back to facility by ambulance. The Note documented "NNO (No New Orders.) POA (Power of Attorney) is aware." Facility's AIM for wellness form, dated 7/31/21, documented "bump to right side back of head noted by 10:00 PM - 6:00 AM nurse." The form documented R2 was sent to ER for evaluation. The form documented "Manage: physician recommendations and/or nursing interventions: send to ER for evaluation." The form was signed on 7/31/21 at 9:00 AM. There is no documentation in R2's medical record the facility implemented progressive interventions to address R2's fall and need for supervision and to prevent her from future falls. R2's Nurse's Note, dated 8/4/21 at 12:28 AM, documented "Heard res yell out 'aww' and loud noise coming from room (resident room) nurse ran to room and noted res seated on floor on buttocks bleeding profusely from 4 cm (centimeter) x (by) 0.2 cm laceration to mid-hairline upper forehead pressure and cool compress applied. 12:30 AM call placed to ambulance service to arrange for transport to ER. states pain to bilateral knees but non-compliant and refused to allow nurse to assess moving extremities independently AROM (active range of motion). Res (Resident) crying and yelling wanting to see her mother reassurance given per writer en route to ER call placed to NP and	S9999		

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S9999	Continued From page 6	S9999		

notified of fall with injury and transfer. 12:50 AM POA notified of fall with injury and transfer to ER 12:55 AM call placed to (local hospital) gave report to (Registered Nurse) or res fall and condition on transfer 1:00 A.M. Call placed to (V14 Unit Coordinator) and notified of all the above. 8/4/21 1:30 PM continue on incident follow up (IFU) for fall laceration to mid forehead no signs or symptoms of infection to mid forehead complaint of head pain PRN Tylenol given. Resident walks with walker and reminded to slow down when walking gait unsteady at times."

Facility's AIM for wellness form dated 8/4/21, documented R2 fell and sustained a laceration to forehead. The form documented R2 fell three times since mid-July 2021 sent to ER for evaluation. The form documented "Functional status evaluation: falls (more than one), behavioral evaluation: danger to self or others, depression, aggression, skin evaluation: laceration, wound 4 cm laceration to mid upper forehead at hairline, pain evaluation: forehead, scalp, knees 7/10 pain intensity with grimacing." The form was signed at 1:15 AM.

Facility's Investigation report for skin tears/bruises, dated 8/4/21, documented assistive devices in good working order and without any sharp, rough or torn areas: walker nearby and turned over on its side.

There is no documentation in R2's medical record the facility implemented progressive interventions to address R2's falls, need for increased supervision and to prevent her from future falls.

On 8/20/21 at 10:54 AM V15 Therapy Director, stated "(R2) has declined cognitively and physically over the last 9 to 12 months. (R2) has

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S9999	Continued From page 7 had a lot of falls and they have worked with her often. She does not always remember to use her walker. Staff are instructed to keep her walker close to her at all times for a visual cue to remind her to use it." On 9/1/21 at 1:30 PM V3 Assistant Director of Nurse's (ADON), stated she feels R2 is falling due to the dementia disease process. V3 stated R2 should not get up by herself and she is often volatile. The Facility's Fall Prevention Policy, revised 11/18/2018, documents "Immediately after any resident fall the unit nurse will assess the resident provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an AIM for Wellness form along with any new intervention deemed to be appropriate at that time. The unit nurse will also place any new intervention on the CNA assignment worksheet. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan." The Facility's Incident Investigation form dated 8/17/21 documented V15's (Housekeeper) account as between 10:30 AM and 11:00 AM, V15 stated she was cleaning rooms on the looking glass unit and R6 was going in and out of other resident's rooms when R6 approached R2's room and tried to shut the door. V15 documented R2 held the door handle on the	S9999		

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S9999	Continued From page 8 inside of her room they pulled R2's door back and forth hard enough to hear it slam each time. R2 yelled at R6 to stop. V15 documented a Certified Nurse's Assistant (CNA), or nurse came and got R6 a few minutes later. R2's Physical Therapy (PT) daily treatment note, date 8/18/21 with no time, documented R2 was in bed. The Note documented R2 refused to participate in therapy and demonstrated agitation secondary to voicing right upper extremity pain. The Note documented there was bruising on R2's right wrist and pain and bruising was reported to the nurse. R2's Nurse's Note dated 8/18/21 at 1:55 PM, documented R2 complained of arm pain. Facility's AIM for wellness form dated 8/18/21, documented R2 had complaint of pain to right wrist. The form documented R2 held right arm tight and twisted it at times. The form documented "Behavior: aggression and yelling and staff, skin: contusion and bruising started at approximately 12:00 PM, pain was 8/10 (8 out of 10 with 10 being the worst pain). The form documented "Nursing note: CNA told this nurse that resident complained of pain to her right forearm, wrist and hand. Assessed arm no bruising at 7:00 AM, bruising appeared at until around 12:00 PM. Resident noted to squeeze arm tight at times. Resident guarding arm and will not use walker, she stated that it hurts too bad to use walker. NP (Nurse Practitioner) and POA (Power of Attorney) notified. NP will visit today to look at her arm." V13, Licensed Practical Nurse (LPN) signed the form on 8/18/21 at 10:30 AM. R2's Nurse's Note, dated 8/18/21, at 4:00 PM documented "(NP) here to look at R2's right	S9999		

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S9999	Continued From page 9 arm/wrist NO (new order) x ray to rt (right) hand and arm POA notified." There was no documentation the Xray was obtained after Nurse Practitioner saw R2 at 4:00 PM. R2's Physician's Order (PO), dated 8/18/21 with no time, documented "Xray right hand, are wrist. Use Tylenol as ordered PRN. R2's Nurse's Note, dated 8/18/21, at 10:30 PM, documented arrival at night shift a physician's order for x-rays called x-ray company need STAT (immediately) x-rays. R2's physician's telephone order sheet dated 8/18/21 at 10:30 PM, x-ray right arm due to complaint of pain/discomfort. R2's physician's order sheet, dated 8/18/21 with no time, documented "Obtain x-ray right hand, forearm and wrist STAT (immediately.)" R2's Nurse's Note, dated 8/18/21 at 11:50 PM, documented " x-ray here to obtain x-rays (R2) was uncooperative, cursing at tech refusing to position so that x-rays can be obtained CNA and nurse assisted with (R2) screaming and trying to run away from x-ray technician and threatened to slap x-ray technician finally after 20 minutes was able to get x-rays." The Note documented "11:55 PM, documented x-ray technician reported preliminary results showed fracture to right forearm." The Note documented 12:30 AM, call placed to V1, the Administrator after attempting several times and reported findings call placed to ambulance service for transportation to ER (Emergency Room). NP called for orders. At 12:50 AM, the resident's POA informed of	S9999		

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S9999	Continued From page 10	S9999		

pending transfer to a local ER. At 1:00 A.M., ambulance here and resident transported on stretcher. Her right forearm was wrapped with ace wrap. Resident was resistant and verbally aggressive."

R2's Xray report, dated 8/18/21, documented "Impressions: acute, mildly displaced distal ulnar fracture."

R2's August 2021 Physician's Order Sheet (POS), dated 8/19/21 documented "send to (local hospital emergency room) for eval (evaluation) and tx (treatment)."

R2's PO, dated 4/22/2019, documents "Acetaminophen, 325 mg (milligrams), take 2 tables '650 mg' by mouth every 8 hours as needed."

R2's Medication Administration Record (MAR) dated August 2021, documented R2 did not receiving any Acetaminophen (Tylenol) on 8/18/21.

R2's nurse's note dated 8/19/21 at 4:10 AM documented she was readmitted to the facility from the hospital with a diagnosis of a distal right ulna fracture a soft splint and ace wrap was applied at the ER. No complain of pain or discomfort voiced.

R2's Nurse's note dated 8/19/21 at 1:40 PM documented R2 resting quietly in bed. She refused breakfast this morning and ate 100% of lunch. Complaint of right arm pain hurting, administered Tylenol and she has been resting.

On 8/31/21 at 1:17 PM V3, Assistant Director of Nurses, ADON, stated she expected staff to

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S9999	Continued From page 11 contact the x-ray company as soon as an x-ray order is obtained from the NP. V3 stated "The standard for an x-ray wait time is four to six hours, but it varies depending on the workload of the x-ray technician. Staff should have followed up on the x-ray after six hours." V3 stated she was aware the x-ray was not done by 10:00 PM and it was then ordered STAT (immediately). V3 stated the memory care/looking glass unit residents have dementia and are moderately to severely cognitively impaired. V3 stated R2 is a resident who cannot express pain on a pain scale, but she can express pain verbally, via facial grimacing and/or guarding the area of pain. V3 stated she expected staff to administer pain medication in a timely manner, document where the compliant of pain was located then reassess the resident for pain during the next interaction with the resident. "B"	S9999		