STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001739	A. BUILDING: _____ B. WING _____	C 10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

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S 000	Initial Comments Facility Reported Incident of 10/13/21/IL139403 F689G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	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. Restorative measures shall include, at a minimum, the following procedures: 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. 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 Regulations were not met as evidenced by: Based on interview and record review, the facility failed to provide supervision to prevent a resident fall for one resident (R1) reviewed for falls with injury. These failures resulted in R1 falling on 10/13/21 and dislocating the left hip and fracturing the left femur requiring hospitalization for surgical repair. Findings include:	S9999		

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S9999	Continued From page 2 The Facility Fall Prevention-Steady Steps policy, last revised on 2/17/21, states, "It is the policy of (this facility) to provide each resident with an appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. Additionally, all resident falls in this community are analyzed and trended through the QAPI (Quality Assurance and Performance Improvement) process to determine if additional measures are required by the community to decrease falls including but not limited to Performance Improvement Project. Residents will be evaluated for risk of falls on admission, quarterly, and significant change. Residents who are evaluated as at risk for falls will be identified by a Fall Risk Score of 4 or greater. A Patient Fall Risk Questionnaire will be completed on admission/readmission and a change in condition that could potentially affect the resident's fall risk to assist the interdisciplinary team in determining any additional interventions. Residents identified as at risk for falls, will have clinically appropriate interventions put into place to reduce the risk for falls and/or to prevent recurrence of falls. The Interdisciplinary Team will review and modify the fall risk prevention plan of care at a minimum of quarterly, after each fall, and as clinically indicated. Interventions for the falls prevention plan will be modified following the interdisciplinary review and changes will be made to the plan of care accordingly. R1's electronic medical record documents R1 was admitted to this facility from the hospital on 10/11/21 at 3:20 p.m. with diagnoses which included, Stroke (Cerebral Vascular Accident) with left sided weakness (Primary diagnosis), Dementia, Urinary Tract Infection, and Cognitive Communication Deficit.	S9999		

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S9999	Continued From page 3 R1's Hospital History and Physical dated 9/28/21 (referral packet sent to the facility on 10/6/21) documents R1 was a 90 year old female with a history of Dementia presented with symptoms of a stroke (left sided weakness, left facial droop and slurred speech); R1 had 24 hour caregivers at home prior to admission; R1 was unable to provide history. R1's Initial Care Plan (Kardex) dated 10/11/21, documents R1 had modified independence with daily decision making (experienced some difficulty in decision making when faced with new tasks or situations), was a high risk for falls and required "frequent checks", required assistance with transfers; used a wheelchair for locomotion and was not steady moving from seated to standing position. R1's Admission Fall Risk Questionnaire, completed with R1 and R1's family, documents R1 had falls in the past 12 months (prior to admission) with no specific information documented in the comments section; R1 feels unsteady when walking or standing up sometimes; R1 currently uses a wheelchair; R1 does have to rush to the bathroom at times; and R1 is incontinent of bladder. The Facility's Occupational Therapy note dated 10/12/21, documents R1 had a caregiver 24 hours per day prior to hospitalization; R1's Precautions were Fall Risk due to confusion; R1 was oriented to self only; R1 required cues/redirection for safety on 4 occasions during the evaluation. The Facility's Speech Therapy Plan of Care dated 10/12/21, documents R1 scored as having severely impaired cognition; R1 demonstrated	S9999		

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S9999	Continued From page 4 severely impaired functional problem solving and safety awareness for daily living tasks. R1's Post Fall Review dated 10/12/21, documents R1 fell in her room on 10/11/21 (at 7:45 p.m.) with no injury. R1's Post Fall Huddle dated 10/11/21 at 7:45 p.m., documents the following: R1 was a new admission in the past 72 hours, R1 was in bed for the night, and R1 was attempting to get dressed at the time of the fall. The Post Fall Huddle also documents R1 should be re-directed and monitored closely to prevent any further falls. R1's Post Fall Review dated 10/12/21, documents the root cause analysis of this fall was "Poor safety awareness (related to R1's diagnosis) of Dementia." This same Post Fall Review, documents that "New Interventions implemented appropriate to the root cause analysis of the fall: 1. Place a call don't fall sign in (R1's) room and 2. Provide activity at nurses station when (R1 is) noted to be restless." On 10/24/21 at 12:50 p.m., V3 (Certified Nurse Aide) stated V3 was R1's Certified Nurse Aide on the 2:00 p.m. to 10:00 p.m. shift on 10/11/21 (R1's date of admission). V3 stated R1 had shown confusion due to her diagnosis of Dementia but was able to make some of her needs known. V3 stated after supper at approximately 6:45 p.m., V3 toileted R1, put a nightgown on R1 per R1's request, and put R1 in her recliner in her room. V3 stated that before V3 left the room, she folded R1's dirty clothes that she had just removed and placed them in R1's wheelchair. V3 stated within an hour of putting R1 in the recliner, V3 walked by R1's room and R1 was on the floor by the wardrobe and R1 was fully dressed in the clothes that V3 had folded and left in the wheelchair. V3 stated R1 was confused and told V3 that she wanted to get dressed	S9999		

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S9999	Continued From page 5	S9999		

before her husband got home. V3 stated V3 had not checked on R1 for approximately an hour before she fell. V3 stated R1 had not been in bed prior to this fall (as documented on the Post Fall Huddle). V3 stated R1 needed close supervision when she had confusion and didn't remember she could not walk after having the Stroke.

R1's Incident Report sent to the State Agency dated 10/14/21, documents the following: On 10/13/21 at 10:30 p.m., R1 was found on her bathroom floor lying on her right side. A Nursing assessment was completed and noted outward rotation of R1's left leg. Physician orders were received to send R1 to the local hospital for evaluation. R1 was sent to the local hospital and diagnosed with a left hip dislocation and femur fracture and R1 was then transferred to a larger hospital for surgery.

R1's Post Fall Review dated 10/13/21, documents the Root Cause Analysis of R1's fall on 10/13/21 was "Poor safety awareness related to (diagnosis) of Dementia." R1's Post Fall Huddle dated 10/13/21, documents the following: R1 was ambulating without assistance or walker at the time of the fall; R1 was last seen one hour prior to fall lying in bed; R1 had socks on her feet; Interventions listed to prevent further falls was "slipper socks when in bed."

R1's Hospital Radiology Report dated 10/13/21, documents R1 had a "Mildly displaced angulated fracture in the proximal left femur." R1's Hospital Operative Report dated 10/14/21, documents R1 had surgical repair to the left femur fracture.

On 10/24/21 at 12:31 p.m., V8 (Certified Nurse Aide) stated V8 had just started her shift on 10/13/21 at 10:00 p.m. V8 went down the 100 hall

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S9999	Continued From page 6 and was shutting off lights and televisions and "laying eyes on the residents." V8 noticed that R1's main room light and her bathroom light were on. V8 entered R1's room and found R1 on the bathroom floor with obvious injury to her left leg. On 10/24/21 at 5:33 p.m., V10 (R1's daughter) stated, "My sister and I went over to the facility on 10/19/21 and discussed (R1's) falls with (V1, Administrator and V2, Director of Nursing). We wanted to know how (R1) could have fallen twice in less than the three days that she lived there. There was no excuse for (R1) to end up with a broken hip. We had 24-hour care for her when she was still at home before she had the Stroke. We even told her admitting nurse on 10/11/21 that my family had sat with her at the hospital every day from 8:30 am. to 5:00 p.m. That's when we also told the nurse that (R1) had 24-hour care at home. We made it very clear that (R1's mental status) had been the issue prior to the stroke. We sent (R1) to a long-term care (the facility) to get increased supervision and therapy so she could walk again. What we got was (R1) in worse shape than when she arrived less than three days prior. We couldn't let (R1) go back (to the facility). (R1) was finally discharged from the hospital to a new long-term care facility on 10/22/21." On 10/24/21 at 11:42 a.m., V2 (Director of Nursing) stated after R1 was discharged (10/13/21), V2 found out from R1's family that R1 had 24-hour care when she was at home prior to R1's Stroke. V2 stated, "If I had known that, I would have put R1 in a room across from the nurses station or on the Dementia Unit. V2 stated, "The Dementia Unit runs differently. They keep the residents in small pods so if they try to get up without assistance, (the staff) are right there with them until they are ready to go to	S9999		

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sleep. They monitor them very closely due to their confusion. That extra supervision (the staff) are able to provide on the Dementia Unit could have kept (R1) from falling. It would not be unusual for a resident with a new history of (a Stroke) and Dementia, to be extremely confused when placed in a new environment." V2 stated a new Stroke patient with Dementia often forgets their physical limitations and will attempt to function at their prior level which often results in the resident falling. V2 stated the facility's Liaison screened R1 for placement in the facility but there is no documentation other than the hospital records that were received with R1's referral on 10/6/21. V2 stated V2 should have been informed that R1 had 24-hour care at home.

On 10/24/21 at 6:04 p.m., V1 (Administrator) stated R1 did not return to the facility after her hospitalization for the left hip fracture. V1 stated she is now aware that R1's hospital records that were sent to the facility on 10/6/21 for R1's admission referral and the facility's Therapy notes both documented that R1 had 24 hour care when she lived at home prior to having the stroke. V1 stated, "I'm not sure how that was missed." V1 stated increased supervision could have potentially prevented R1's falls on 10/11/21 and 10/13/21. V1 stated R1's medical records from the hospital and from the facility admission assessment, could have been better utilized in planning R1's care.

(A)