| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S 000 | Initial Comments<br><br>Facility Reported Incident of May 1, 2021/IL134102 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.690b)<br>300.1210b)<br>300.1210c)<br>300.1210d)6)<br>300.1220b)3)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.690 Incidents and Accidents<br><br>b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. | S9999 | Attachment A<br>Statement of Licensure Violations | |

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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.

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 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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident

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| S9999 | Continued From page 2<br>care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These regulations are not met as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to effectively monitor and supervise a legally blind resident, failed to evaluate and update care plan interventions following each fall, and failed to implement individualized care plan interventions for fall prevention and failed to report a fall with injury as per their policy for one of three residents (R3) in the sample reviewed for falls. These failures resulted in R3 experiencing multiple falls with injuries that required hospital treatment.<br><br>Findings include:<br><br>R3's diagnoses (per face sheet) include but not limited to Legal blindness, Malignant Neoplasm of Larynx, Conversion Disorder with Seizures and | S9999 | | |

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| S9999 | Continued From page 3<br>Syphilis Unspecified.<br><br>On 7/12/21 at 10:26 am, observed R3 in his room asleep on a low bed pushed all the way against the wall and fall mat was observed on one side of the bed.<br><br>On 7/13/21 from 9:03am until 12:45pm, R3 was intermittently awake or asleep in a low bed with fall mat on one side, with bed pushed back against the wall.<br><br>On 7/14/21 at 10:14am, with V4, ADON (Assistant Director of Nursing) visited R3. R3 was awake. Observed R3 unable to see, able to pull call light when in his hand, and able to stand up and walk. Observed V4 and a staff assist R3 to walk in room.<br><br>On 7/14/21 at 1:13pm, observed R3 asleep in low bed with no fall mat. V10 was asked if R3 has fall mat on the floor, V10 said no, and to ask Restorative.<br><br>R3 had a history of falls according to the following information:<br><br>1. R3's progress notes dated 5/1/21 at 11:31pm documented, R1 was found on the floor lying face down ....noted with a cut to the left side of fore head at the end of his left eyebrow. R3 was sent to Emergency Room for treatment.<br><br>Local Hospital Emergency Room documents dated 5/2/21, R3 had a 2.5 centimeter laceration on the left eyebrow region, requiring sutures. CT (Computed Tomography/computerized x-ray imaging) of the Head done with results: "Impression: New 7.4mm well defined focus of high density within the posterior aspect of the left | S9999 | | |

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insula compatible with small focus of subarachnoid hemorrhage" (Brain bleed). R3 was transferred to a local Trauma Hospital for further evaluation (per 5/2/21 facility progress notes).

R3 returned to the facility on 5/3/21 (per progress notes), with diagnosis of Subarachnoid hemorrhage, head injury, nasal bone fracture, left orbital fracture and left eyebrow sutures.

2. R3's progress notes dated 5/4/21 4:24am documented, R3 was "found sitting on the floor with a small amount of blood near the top of his head. A small laceration was found near the top of the forehead. R3 was sent to a local hospital for treatment.

3. R3's Progress notes dated 6/10/21 2:10pm documented, "Resident is placed on floor per his care plan to prevent fall. Resident hit his head trying to roll from side to side on his floor bed. Skin cut on his forehead." R3 was sent to Emergency Room.

R3's Emergency Room documents dated 6/10/21 stated in part; "The patient states that he attempted to get out of his bed and fell onto the ground hitting the left side of his head." CT of the Facial bones result showed "Mild preseptal soft tissue swelling of left orbit" and CT of the brain result showed "Mild soft tissue swelling with laceration over the left frontal calvarium (part of the skull). A three centimeter laceration of the frontal scalp was sutured."

4. R3's progress notes dated 6/16/21 8:15am stated in part; "Staff made aware resident was observed on the floor in his room. Resident noted lying on left side in room with floor mat in place

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| S9999 | Continued From page 5<br>.... Noted with open area above left eyebrow."<br><br>R3's local hospital document dated 6/16/21 stated in part, "Patient presented from the nursing home after he fell and hit his head. Patient was found to have a laceration of the forehead for which he received stitches. He was discharged back to the nursing facility. Following discharge chest x-ray reported left sided pneumothorax and therefore the patient was called back to the hospital." 6/16/21 History and Physical Examination Assessment and Plan indicated, "Pneumothorax: likely traumatic". Treatment for the forehead laceration included "Wound closure Derma bond Advanced". A 6/16/21 Chest X-ray result "moderate to large left sided pneumothorax persists, slightly increased in size compared to the previous exam."<br><br>The following interviews were conducted regarding R3's falls:<br><br>On 7/13/21 at 9:53am, V10 (Licensed Practical Nurse), on duty at the time R3 alleged fall on June 16, 2021, said "R3 was in bed at that time, behavior was agitated, redirected couple of times, we have been there a couple of times to redirect him. I gave him Ativan to calm him down ....he is visually impaired. We check on him at least every hour. Injury, he had a laceration on the left eye brow and was sent to the hospital. The bed was on low position and floor mat was in place." V10 was asked how R3 sustained injury with the low bed and fall mat. "It was an unwitnessed fall but he probably stand up and attempted walking."<br><br>On 7/14/21 at 9:54am, V10 was asked what other interventions can be done for R3 to prevent falls. V10 said, "At this point it would be one on one supervision, or put him on the Broda chair here in | S9999 | | |

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| S9999 | Continued From page 6<br>the nursing station."<br><br>On 7/13/21 at 2:10pm V4, ADON, who was the facility Fall Coordinator said, "R3 attempts to ambulate which cause him to fall." V4 also indicated "R3's gait was impaired, and judgement poor. The fall interventions in place for R3 were frequent monitoring, fall mat, low bed, call lights, toileting and inclusion in Falling star program and bringing R3 to the nursing station where multiple staff can watch him." V4 also said "Restorative evaluate R3 for other fall interventions such as alarms which he had in the past but discontinued because it was not effective." V4 also said that "the other option was for R3 to be on one to one, but we cannot always provide one to one."<br><br>On 7/14/21at 10:47am, V12 (Restorative Nurse) said "The IDT (Interdisciplinary Team) makes the decision what intervention to put in place for a resident who keeps on falling. Fall mat is not indicated for R3 because when he tries to ambulate he can trip over the fall mat. If he fall from the bed then low bed will break the fall."<br><br>R3's nursing care plan addressed care issues including falls on the following dates:<br><br>8/21/20: Continue to assist with dressing and grooming. Therapy to evaluate. Therapy to evaluate on return.<br><br>5/3/21 upon return will be added to falling star program. Will encourage to engage in scheduled activities and be placed on location monitoring and offered toileting. Educated to use call light and ask for assistance for transfer. Kept in high visual places. Continue with dressing and grooming. | S9999 | | |

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| S9999 | Continued From page 7<br>6/17/21 upon return, will be evaluated for appropriate safety devise. He will continue with low bed and continue to keep in common area when possible. Educated on call light and ask for assistance for transfer. Kept in high visual area. Continue to assist in grooming. Upon return will be added to star program.<br><br>A fall mat was not included in any of the care plan reviewed.<br><br>Policy and Procedure titled Falls and Fall Risk Managing<br>6. Staff will identify and implement relevant interventions .... to try to minimize serious consequences of falling.<br><br>On 7/15/21 at 11:30am V1 (Administrator) was asked if R3's fall incident occurred on June 16, 2021 was reported to state agency. V1 said, "No, it was not reported."<br><br>Facility's Abuse Prevention Policy: Any allegation of abuse or any incident that results in serious bodily injury will be reported the Illinois Department of Public Health immediately, but not more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.<br><br>(A) | S9999 | | |