STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005250	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA SALLE COUNTY NURSING HOME	1380 NORTH 27TH ROAD OTTAWA, IL 61350

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S 000	Initial Comments Facility Reported Investigation (FRI) Incident of 8/2/21/ IL136648	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)2)3) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 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 2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident 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	S9999		

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S9999	Continued From page 2 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. These requirements were not met evidencded by: Based on observation, interview, and record review, the facility failed to ensure bed brakes were locked while providing care, failed to ensure two staff assist for bed mobility, dressing for two residents, and failed to provide the appropriate size bed for safe bed mobility for two (R1, R2) of three residents reviewed for falls. This failure resulted in R1 sustaining a scalp laceration with sutures, shoulder, and scalp contusions and an 18-centimeter skin tear. Findings include: R1 was admitted to the facility on 5/6/19 and has current diagnoses that include Lung/Brain Cancer, Hemiplegia status post Stroke and Obesity. Current Comprehensive Assessment dated 7/19/21 indicates R1 is severely cognitively impaired and is two (plus) person total assists with bed mobility, transfers, and dressing. Weight and Vital Signs record dated 8/4/21 indicates R1 weighs 189 pounds. Progress Note dated 8/2/21 at 6:16am indicates "During cares at 5:25am, (R1) rolled out of bed and hit the floor face first." Note indicates R1 sustained lacerations to her head, large	S9999		

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S9999	Continued From page 3	S9999		

hematoma on right side (of head) and large skin tear from elbow to wrist on right arm. Note indicates ambulance was called and R1 was transferred to the hospital at 5:40am.

Progress Note dated 8/2/21 at 9:20am indicates R1 returned from the hospital and is noted to have four sutures to top middle of head and one suture to right upper outer forehead; right posterior shoulder with approximate 2cm (centimeter) bruise, right forehead bruising and swelling; 3cm open area to right arm, 4cm wide by 18cm in length.

Hospital Records dated 8/2/21 at 8:08am indicate R1 was seen on that date due to a fall and was diagnosed with a scalp laceration with sutures, scalp contusion, contusion of right shoulder and a skin tear of right forearm.

Investigative Summary (Incident) Report-dated 8/2/21 indicates that (V7, CNA/Certified Nurse Assistant) was providing cares to R1 in bed. Report indicates as V7 began to turn R1, the bed shifted forward away from V7 with R1 falling and landing "front down" and R1's head having contact with a bedside chest during the descent.

Report indicates R1 is alert, and oriented to person only, non-ambulatory and dependent for all transfers.

Report indicates Root Cause of fall: Bed moved as R1 was being turned for cares. Report indicates brakes on bed are functional.

On 8/4/21 at 11:47am V7, CNA stated that R1 is total care - unable to move arms or legs, can't assist with any movement and that R1 is "dead weight." V7 stated that she was almost done with

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S9999	Continued From page 4	S9999		

care, pulled R1 toward her to get her pants on and the bed "shot back" and R1 rolled to the floor. V7 stated that the lock on the bottom of the bed "unlocked, popped up and the bed shot over." V7 stated that she can provide care for R1 by herself including turning, dressing, and incontinent care. V7 stated there is nothing specific in their charting that tells them if a resident should be one assist or two. V7 stated that beds can be moved by housekeeping, maintenance, or other nursing staff and sometimes don't get re-locked.

On 8/4/21 at 12:15pm V2, DON (Director of Nursing) stated that the staff providing the care to a resident is ultimately responsible to ensure the brakes are locked on a bed or a wheelchair. Facility Policy/Strategies for Managing Falls dated 2007 documents:
Make sure bed is locked and in lowest position "related to toileting needs."

On 8/4/21 at 12:30pm V5 and V6 CNA's were transferring R1 from a chair into bed. At that time both V5 and V6 stated that they always have two CNA's to transfer R1 because she is a mechanical lift transfer. Both V5 and V6 stated that R1 only requires one staff to assist with bed mobility, dressing and incontinent care. V5 stated that the CNA's use an information sheet that's kept at the nurse's station to know how many staff are required to transfer a resident but the flow sheet does not identify how many staff should assist with bed mobility.

On 8/4/21 at 1:45pm V3, Restorative Nurse stated, "If I could get two CNA's to provide care for these heavy residents - I would."

On 8/5/21 at 2:00pm V3, RN stated that the Bed should be locked for all care, not just toileting.

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S9999	Continued From page 5 "Our policy needs to be updated and revised." V3 acknowledged that it is harder for both the CNA and on the resident to change, dress, and turn a totally dependent resident with only one person. V3 stated there is no assessment for bed mobility, "CNA's just know how many it takes to care for the resident." V3 agreed if there had been two CNA's taking care of R1 before she fell, one of the CNA's may have been able to prevent the bed from moving and possibly prevented R1 from rolling out of the bed. Facility Policy/Positioning the Resident dated 2008 documents: To move a resident up in bed/When a resident is helpless: Two-person lift - two staff members may stand on the same side or on one side. Both staff members lift resident into desired position. To use a pull sheet under the resident - have a staff member on each side of the bed. 2) R2 was admitted to the facility on 5/6/19 and has current diagnoses that include Morbid/Severe Obesity, Diabetes Mellitus and Pseudobulbar Affect. Weight and Vitals Record indicates on 8/4/21 R2 weighed 346 pounds. Dietary Note dated 7/12/21 at 1:31 indicates R2 has a BMI (Body Mass Index) of 48.8/Class III Obesity. Comprehensive Assessment dated 7/12/21 indicates R2 is extensive assist of two staff for bed mobility and total assist of two staff for dressing. On 8/5/21 8:45am R2 was observed sleeping in	S9999		

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bed on his right side. R2's body took up the entire width of the bed with his stomach/abdomen hanging off the right side of the bed. The bed was not wide enough to contain the entire width of R2's body.

On 8/5/21 at 11:04am R2 was receiving care (incontinent, dressing) in bed by V8, CNA. No other staff was assisting V8 with R2's care. R2 could only minimally turn from side to side in the bed and had to hold on to the trapeze above the bed to assist in turning. Despite using the trapeze, R2 could not fully turn in the bed due to the small size of the mattress/bed. R2 refused to answer questions at that time.

On 8/5/21 at 2:00pm V3, Restorative Nurse stated that he agrees R2 needs a bigger bed and that R2 has a bariatric reclining chair and should have a bariatric bed. V3 acknowledged that both R2's bed size and only one staff providing care could be a potential fall risk for R2.

Current Care Plan indicates R2 had an actual fall on 6/3/21 with no injuries due to R2 leaning out of bed and R2's noncompliance with maintaining a safe bed position. Care plan also indicates R2 had an actual fall on 6/12/21 with injuries to right forehead, facial abrasions and foot injuries related to poor resident safety awareness and poor awareness of position in bed.
Care Plan intervention dated 6/9/21 was to place a floor mat on the floor next to R2's bed.
Care plan intervention dated 6/14/21 was to fit R2 for a reclining chair.
No interventions were initiated to address R2's poor safety awareness or poor awareness of position in bed.

Restorative Progress Note dated 6/7/21 at

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S9999	Continued From page 7 4:20pm indicates V3, Restorative Nurse spoke to R2 "Concerning safety in relation to R2's recent fall - specifically the height of the resident's bed to promote resident safety." Note indicates R2 was able to operate the controls for raising/lowering the bed and R2 was educated on the bed control keypad. This problem and intervention were not found on R2's current care plan. On 8/5/21 at 2:00pm V3, RN stated R2's poor bed positioning and interventions should have been implemented on R2's care plan. Current Care Plan indicates to use a draw sheet or lifting device to move R2 (in bed). Facility Policy/Positioning the Resident dated 2008 documents: To use a pull sheet under the resident: Have a staff member on each side of the bed. " B"	S9999		