STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005060	A. BUILDING: _____ B. WING _____	C 08/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOX COUNTY NURSING HOME	800 NORTH MARKET STREET KNOXVILLE, IL 61448

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S 000	Initial Comments Facility Reported Incident Investigation to Incident of 8/17/21/ IL137327.	S 000		
S9999	Final Observations Facility Reported Incident Investigation to Incident of 8/17/21/ IL137327. STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)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	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. Section 300.1210 General Requirements for Nursing and Personal Care 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. These Regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to provide sufficient supervision to prevent a fall with major injury for one of three residents (R1) reviewed for falls in a sample of three. This failure resulted in R1 walking without her walker or staff assistance causing R1 to fall sustaining a laceration to the forehead, a laceration to the right hand and a fracture to the right proximal phalanx of the little finger and a fracture to the base of the phalanx of the right ring finger. Findings include:	S9999		

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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9999	Continued From page 2	S9999		

A Falls and Fall Risk, Managing policy dated 3/2018 states, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling." In addition, this policy states that conditions that may contribute to the risk of falls include delirium or other cognitive impairment, functional impairments, and incontinence. This policy also instructs, "The staff with input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls."

R1's Minimum Data Set (MDS) assessment dated 7/8/21 documents R1 is severely cognitively impaired and requires limited assistance of one person for transfers, walking in R1 room and walking in the corridor; and requires extensive assistance of one person for toilet use and personal hygiene.

R1's Fall risk assessment date 7/8/21 documents R1 is at high risk for falling because R1 has had previous falls, has multiple medical diagnoses, uses a mobility device such as a walker, exhibits a weak gait, and overestimates or forgets the limits of R1's abilities to ambulate safely.

R1's care plan states under the focus of physical mobility needs that R1's, "Ambulation: Requires supervision to limited assistance with one staff, walker." and "Provide close supervision and watch for early signs of agitation or increasing anxiety and report." R1's care plan also documents that R1 is receiving Hospice services due to terminal prognosis secondary to diagnoses including Senile Degeneration of brain and

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S9999	Continued From page 3 Dementia. In addition, R1's care plan instructs, "Increase supervision during times of wandering." This same plan includes a fall prevention intervention dated 10/1/2020 which instructs staff to supervise R1 with "15 minute visuals." R1's fall investigation final report dated 8/20/21 documents that on 8/17/21 at 10:02a.m. R1 had an unwitnessed fall in R1's room requiring hospitalization where R1 received sutures to a forehead laceration, sutures to a right palm laceration, and sustained a fracture to the fourth and fifth fingers of the right hand. This fall investigation documents that V10 (Housekeeper) heard R1 yelling and went to R1's room to find R1 on the floor, in the middle of R1's room, and bleeding from R1's head and hand. The investigation documents that V10 had last seen R1 in R1 room, in bed, at 9:20a.m. when V10 cleaned R1's room. This investigation also documents that V8 (Activity Aide) and V9 (Activity Aide) saw R1 walking in R1's room without R1's walker, at which that time, they gave R1 her walker and redirected R1 back to her bed. R1's fall investigation documents the root cause of the fall as, "(R1) self-ambulated from bed to R1 window with her walker, then turned and walked toward the center of R1's room without her walker where R1 lost her balance and sat down on the floor bumping the left side of her forehead. Not wearing shoes, incontinent brief was soiled." The fall investigation documents that the intervention developed as a result of R1's 8/17/21 fall was, "During 15 minute visuals staff educated to observe and anticipate resident's needs, make sure R1 has her walker within reach to remind R1 to use walker when/if R1 gets up, as R1 is forgetful of using walker at times." R1's hospital emergency room records dated	S9999		

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8/17/21 documents that as a result of R1's fall R1 required nine sutures to a laceration to R1's forehead, four sutures to R1's right hand laceration, and sustained a fracture to the base of the proximal phalanx of R1's right little finger and a fracture to the base of the proximal phalanx of R1's right ring finger.

On 8/30/21 at 12:00p.m. R1 was seated in a wheelchair in the day room next to the nurse's station with her right hand elevated on a pillow and with folded wash cloths on the table in front of R1. V4 (Certified Nurse Aide/CNA) was in the day room providing supervision for residents seated in the day room, including R1. V4 stated that R1 was already on 15-minute visuals while R1 is in her room or her bed prior to R1's fall on 8/17/21. V4 stated that "Normally we have (R1) sit up in the day room during the day so we can watch R1."

On 8/31/21 at 9:48a.m. V8 (Activity Aide) stated that on 8/17/21 at 9:30a.m. she and V9 (Activity Aide) were walking down R1's hallway asking residents to attend an activity. V8 stated that R1 was standing at R1 door without her walker with no staff assisting R1. V8 stated that R1 was leaning down trying to fix something on the bottom of R1's roommates' bed. V8 stated, "I told her she (R1) can't do that so she wouldn't fall. My coworker (V9) stayed at (R1's) side while I grabbed her walker which was by her closet next to the window. I grabbed the walker and brought it to (R1). Then (V9) directed (R1) to her bed. (R1) sat down on her bed. We thought (R1) would lay down on her bed but she was just sitting there with her walker next to her bed. She didn't lay down." V8 stated, "Usually (R1) will sleep in her bed without someone in the room with her but when she wakes up, the nurses and CNAs will

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S9999	Continued From page 5 put (R1) up at the day room next to the nurse's desk to keep an eye on her." V8 stated that she has never seen R1 in her room by herself before stating, "I normally see her in the day room." V8 stated, " We told both the CNA and nurse that we saw R1 up walking by herself. The nurse was V6 (Registered Nurse) but I'm not sure about the CNA. They just said 'OK. We'll go down there.'" On 8/31/21 at 10:06a.m. V7 (CNA) stated she was R1's CNA on 8/17/21 at the time of R1's fall. V7 stated that she had been making 15-minute visual checks on R1 while R1 was in her room in bed. V7 stated she was on a break at the time of R1's fall. V7 stated that when R1 gets up out of bed, staff take her to the day room across from the nurse's station to supervise her. V7 stated, "We don't leave her alone in her room. We bring her to the day room." V7 stated the practice of keeping R1 in the day room while she is awake was started prior to R1's fall on 8/17/21. V7 stated, "If we see (R1) up walking, we walk with her because she is confused." V7 stated that she documents R1's 15-minute visuals on R1's 15-minute checks sheet. R1's 15 Minutes Checks sheet dated 8/17/21 to 8/18/21 shows that V7 did document R1's 15-minute visual checks from 6:00a.m. to 9:45a.m. on 8/17/21, but the area next to the 9:45a.m. to 10:00a.m. visual check is blank. On 8/31/21 at 10:22a.m. V6 stated that she is R1's regular day shift nurse. V6 stated that R1 makes poor safety decisions and needs to be supervised when R1 is awake and out of bed. V6 stated, "Once (R1) gets up from bed or from a nap, staff take (R1) to the day room for supervision, otherwise, she will wander into other residents rooms or try to pick things up off the	S9999		

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S9999	Continued From page 6 floor, putting her at risk of falls." V6 stated that keeping R1 in the day room for supervision while R1 is awake has been in practice since before R1's fall on 8/17/21. V6 stated that she was not notified by V8 and V9 at 9:30a.m. on 8/17/21 that R1 was awake and walking around her room unattended. V6 stated that if she had been notified, she would have taken R1 to the day room for supervision. On 8/31/21 at 11:33a.m. V2 Director of Nurses stated, " All staff, including ancillary staff such as housekeeping or activities, know that they should not leave residents such as (R1) unattended while up in their rooms and should tell their nurse or CNA right away." V2 stated that at the time of R1's fall on 8/17/21 at 10:02 a.m., V7, R1's CNA, was on her break but that any staff could have made R1's 15-minute visual check. (B)	S9999		