STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009377	A. BUILDING: _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE	1615 SUNSET AVENUE WAUKEGAN, IL 60087

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S 000	Initial Comments Facility Reported Incident #131116	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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. 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. Restorative measures shall include, at a minimum, the following procedures:	S9999	Attachment A Statement of Licensure Violations	

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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 supervise a resident who has history of repeated falls and failed to put fall interventions in place for these repeated falls. This failure resulted in R1 falling and sustaining a fracture in her right ankle.

Findings include:

R1's Physician Order Sheet dated 2/21 shows R1 had diagnoses of Dementia with behaviors and Alzheimer's Disease.

R1's facility assessment dated 12/3/2020 shows R1 is severely cognitively impaired. The same assessment shows R1 needs assistance of 1 person physical assist for bed mobility and transfers.

R1's fall risk assessment dated 2/7/2021 shows R1 is at high risk for falls. R1's medical record also shows R1 had fallen repeatedly on the following dates: 12/2/20, 12/15/20, 12/17/20, 1/21/21, 2/7/21 and 2/17/2021.

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The facility Incident Report dated 2/17/2021 sent to the state agency shows "resident was heard crying. Nurse entered the room and observed the resident on the floor with her right ankle caught in the legs of the broada chair. Her right ankle was noted to be reddened and swollen. Resident was sent for evaluation. Returned to the facility with diagnosis of fractured right ankle with a wrap in place."

The facility's final investigation report regarding R1's fall with injury dated 2/19/2021 shows "the resident was attempting to get into her reclined chair and got her foot caught in the frame of the chair."

R1's Emergency Room (ER) note dated 2/17/2021 shows R1 was diagnosed with ankle fracture (right). R1's ER discharge shows R1 needs to see V8. (Orthopedic Physician)

On 2/22/2021 at 9:45 AM, R1 was sitting in her reclined chair watching TV. R1 was wearing a CAM boot (Controlled Ankle Motion) to her right foot. R1 was alert but non verbal.

On 2/22/2021 at 9:30 AM, V2 (DON) said that on 2/17/2021, R1 was found on the floor. V2 said R1 transferred herself unassisted to her chair. V2 said R1 sustained an ankle fracture due to the fall. V2 said R1 has history of repeated falls.

On 2/22/2021 at 5:15 PM, V3 (Registered Nurse) said she was R1's nurse when the incident happened. V3 (RN) said the incident happened at around 4:30 AM (night shift). V3 said she heard R1 yelling. V3 said when she entered R1's room, R1 was on the floor holding unto R1's chair. R1's right foot was caught between R1's reclined chair and R1's chest of drawers. V3 said

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R1's reclined chair and chest of drawers were on the opposite side of the room. V3 said R1 transferred herself unassisted and fell. V3 said R1's right foot was reddened and swollen. V3 said she informed R1's physician and R1 was sent to the Emergency Room (ER). R1 was diagnosed with right ankle fracture. V3 said R1 came back to the facility and R1 was to be referred to Orthopedic. V3 said R1 has history of multiple falls due to unassisted transfers in her room. V3 said R1 should have been monitored more closely. V3 said staff gets busy at night. V3 said R1 is unable to use her call light. V3 said R1 has no device to let staff know she R1 was getting up from bed unassisted.

On 2/22/2021 at 10:55 AM, V4 (Certified Nursing Assistant-CNA) said she was the CNA when the incident happened. V4 (CNA) said she was busy taking care of other residents when her nurse (V3) alerted her to let her know that R1 was on the floor. V4 said when she entered R1's room, R1 was on the floor on the opposite side of the room by R1's reclined chair and chest of drawers. V4 said R1's right foot was tangled around the base of R1's reclined chair. V4 said R1's right leg was black and swollen. V4 said V5 sent R1 out to the ER. V4 said R1 gets up from bed unassisted. and then falls. V4 said R1 needs closer monitoring as she transfers herself and that is the main reason why R1 was falling.

On 2/22/21 at 12:17 PM, V6 (RN) said she is R1's day shift nurse. V6 said R1 needs closer supervision and monitoring due to repeated falls. V6 said R1's room cannot be visualized in the nurses' station. V6 said there is nothing to alert staff when R1 is getting out of bed. V6 said by the time staff can make it to R1's room, R1 had fallen on the floor. V6 said R1 still gets up

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unassisted even when R1's bed was in the low position. V6 said an alarm would be good or other fall interventions to prevent further falls. V6 said R1's latest fall fractured R1's right ankle

On 2/22/2021 at 10:00 AM, V5 (CNA) said R1 is total care. V5 said R1 needs 1 staff when she walks because R1 is unsteady. V5 said R1 is known to transfer without assistance. V5 said R1 falls a lot but staff cannot watch R1 at all times since staff get busy with other residents.

R1's latest careplan did not address the repeated falls on: 12/2/20, 12/15/20, 12/17/20, 1/21/21, 2/8/21 and 2/17 2021. Per R1's medical record accessed on 2/22/2021, most of R1's falls occurred in R1's room due to unassisted transfers. The falls on 12/17/20, 2/7/2021 and 2/17/2021 happened early mornings in R1's room due to unassisted transfers.

On 2/22/2021 at 2:30 PM, V2 (DON) said we were told that R1 was known to be an early riser in the past. V2 said that should have been added to her careplan fall interventions. V2 also said R1's low bed does not stop R1 from getting up from bed and ambulating unassisted then falling. V2 said R1's fall intervention should have also been updated.

R1's Ortho note by V7 (V8's Physician Assistant-PA) dated 2/19/2021 shows R1 was evaluated due to right ankle fracture. The same note shows R1 has distal fibula avulsion fracture.

On 2/23/2021 at 11:14 AM, V7 (Ortho PA) said R1's right ankle fracture (Distal Avulsion Fracture) shows that R1's right ankle was twisted hard enough that have caused R1's right ankle to fracture. This fracture can occur due to a fall. V7

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S9999	Continued From page 5 said R1 was prescribed a CAM boot to her right foot to be worn at all times except bathing. V7 said R1's right ankle fracture will be followed up in 4 weeks for additional X-rays to see the progress of healing on R1's right ankle. V7 said it was important for R1 not to have further falls. The facility policy entitled Fall Program dated 4/2020 shows, When a fall occurs: f. Fall will be reviewed with the Interdisciplinary Team. Discussion will include any trends, education needed or recommendations...Review of interventions and care plan occurs. (B)	S9999		