Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010250	A. BUILDING: ________ B. WING ________	C 03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY MANOR	2345 NORTH SEMINARY STREET GALESBURG, IL 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2121992/IL132090	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE　　TITLE　　(X6) DATE

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S9999	Continued From page 1 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 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. 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 requirements are not met as evidenced by: Based on interview and record review, the facility failed to provide supervision to prevent falls, determine root cause analysis of each resident fall, identify trends/patterns of falls, and implement interventions to decrease the risk of future falls for one of three residents (R1) reviewed for resident injury in the sample of three. These failures resulted in R1 falling on	S9999		

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10/27/20 and fracturing his left clavicle (collar bone) and falling on 12/8/20 and fracturing his left cheek bone.

Findings include:

On 3/30/21 at 2:47 p.m., V1 (Administrator) stated the facility does not have a written policy or procedure for investigating falls. V1 stated when a resident has a fall the nurse creates an "Event Report." V1 stated the following morning the IDT (Interdisciplinary Team) discusses any falls (Event Reports) that occurred since the last meeting and makes sure that there is a thorough investigation completed that includes a root cause analysis and new interventions documented on the care plan to reduce the risk of future falls.

R1's computer generated census report documents R1 was admitted to the facility on 8/11/20 with diagnoses which included, Vascular Dementia with Behavioral Disturbances, Parkinson's Disease, Orthostatic Hypotension, Benign Paroxysmal Vertigo, Repeated falls, Nocturia (urinating frequently at night), Metabolic Encephalopathy, Cerebral Infarction, Anxiety Disorder, Osteoarthritis of bilateral hips. R1's computer generated census report also documents R1 expired in the facility on 1/16/21.

R1's Minimum Data Set (MDS) Admission Assessment dated 8/17/20, documents R1 was cognitively intact on Admission. R1's Significant Change MDS dated 9/23/20, documents R1 had moderately impaired cognition, and R1's Significant Change MDS dated 12/23/20, documents R1 had severely impaired cognition.

R1's Admission Fall Risk Assessment dated

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8/11/20, documents R1 was at high risk for falls.

The Facility's Fall log dated August 2020 through January 2021, documents R1 had falls on the following dates: 8/18/20 at 2:30 p.m., 8/22/20 at 8:10 p.m. , 8/24/20 7:53 p.m., 8/25/20 (2:36 p.m.), 8/25/20 (10:37 p.m.), 8/26/20 (5:00 p.m.), 8/26/20 (5:32 p.m.), 9/2/20 at 4:30 p.m., 9/4/20 at 4:48 a.m., 9/6/20 at 3:24 a.m., 9/9/20 at 5:21 a.m., 9/25/20 at 9:07 a.m., 10/4/20 at 4:30 a.m., 10/8/20 at 5:45 a.m., 10/9/20 8:25 a.m., 10/10/20 at 7:42 p.m., 10/11/20 at 3:41 a.m., 10/13/20 (12:15 a.m.), 10/13/20 (8:05 p.m.), 10/16/20 (12:48 a.m.), 10/16/20 (5:57 a.m.), 10/16/20 (6:08 p.m.), 10/17/20 at 7:22 p.m., 10/19/20 8:15 a.m., 10/23/20 at 1:41 a.m., 10/27/20 at 10:49 a.m. (resulting in fractured left clavicle), 11/12/20 at 2:56 p.m., 11/16/20 at 8:15 p.m., 11/27/20 at 11:30 p.m., 11/29/20 at 10:17 a.m., 12/8/20 at 12:30 p.m.(resulting in fractured cheek bone), 12/14/20 at 5:49 a.m., and 12/17/20 at 4:31 a.m.

R1's falls dated 8/18/20 through 12/17/20, documents R1's had 17 falls that occurred between the night time hours of 8:00 p.m. to 6:00 a.m.

R1's Event Reports document the following falls occurred in/around R1's bathroom, R1 was incontinent or R1 voiced the need to use the restroom: 8/22/20, 8/24/20, 8/26/20, 9/4/20, 9/6/20, 9/9/20, 10/11/20, 10/13/20 at 12:15 a.m. and 8:05 p.m., 10/16/20, and 12/14/20. R1's fall investigations for the above dates do not address R1's falls potentially being related to toileting or R1's diagnosis of Nocturia.

R1's Care Plan dated 8/11/20 through 1/16/21, does not document R1's diagnosis of Nocturia or any interventions to address R1's frequent need

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to urinate at night.

R1's Event Reports dated 10/9/20, 10/11/20, 10/13/20 at 12:53 a.m., 10/13/20 at 8:05 p.m., 10/16/20 at 12:48 a.m., 10/16/20 at 5:57 a.m., 10/19/20, 10/23/20, 10/27/20, and 11/27/20 do not document a thorough investigation with a root cause analysis and interventions implemented to reduce the risk of future falls.

R1's Event Report dated 10/27/20 at 10:49 a.m., documents R1 fell out of his wheelchair. R1's X-Ray report dated 10/28/20, documents R1 had a distal left clavicle fracture as a result of R1's fall on 10/27/20.

R1's Event Report dated 12/8/20 at 12:40 p.m., documents R1 was found on the floor in his room with two small slits in R1's left cheekbone. R1's X-Ray report dated 12/8/20, documents R1 had a left cheek fracture.

On 3/30/21 at 2:47 p.m., V1 stated R1 had a lot of falls during his stay and was "constantly getting up without assistance." V1 stated the staff tried to keep R1 in areas where staff could "keep an eye on him." V1 stated the facility has no documented evidence that R1 was on 1:1 supervision during his stay. V1 stated each one of R1's falls should have been investigated including a documented root cause analysis and appropriate intervention implemented to help reduce the risk of future falls. V1 stated that R1's fall investigations dated 10/9/20, 10/11/20, 10/13/20 at 12:53 a.m., 10/13/20 at 8:05 p.m., 10/16/20 at 12:48 a.m., 10/16/20 at 5:57 a.m., 10/19/20, 10/23/20, 10/27/20, and 11/27/20 were not thoroughly investigated with an appropriate root cause analysis and new interventions implemented on R1's care plan. V1 stated that neither R1's care

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S9999	Continued From page 5 plan nor R1's Fall investigations addressed R1's diagnosis of Nocturia or frequent falls involving R1's toileting needs. V1 stated a thorough investigation would include identifying a pattern of falls, such as times, resident needs at the time of the fall, and locations. On 3/30/21 at 8:45 a.m., V8 (Ombudsman) stated V7 (R1's family member) had requested V8's assistance due to R1 having a very large number of falls during his stay and not getting the supervision he needed to prevent the falls. V8 stated V8 and V7 met with the Care Plan team on two different occasions to discuss what could be done to keep R1 from falling and getting injured so often. V8 stated R1 had approximately 14 falls in October alone. V8 stated R1 had constant skin tears and lacerations but had also had a fractured clavicle and fractured cheek bone. V8 stated the facility did not implement interventions after each fall. V8 stated V8 requested R1 receive 1:1 supervision during the care plan meetings and the facility stated they were not able to provide 1:1 care. V8 stated V1 (Administrator) asked V7 to hire a personal assistant to sit with R1 at all times or have family sit with R1. V8 stated R1's toileting needs seemed to be the biggest reason for R1's falls. V8 stated the staff were not toileting him often enough so R1 would get up by himself and fall. On 3/30/21 at 9:10 a.m., V7 (R1's family member) stated that the facility failed to implement new interventions after R1's falls and R1 just continued to fall. V7 stated she frequently talked to nursing staff and Administration regarding R1's falls. V7 stated the facility refused to provide 1:1 supervision for R1 and that is what R1 required due to his poor cognition. V7 stated R1 ended up with a fractured clavicle and a	S9999		

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S9999	Continued From page 6 fractured cheek bone because of falls due to lack of supervision. V7 stated the facility did not do their "due diligence" to ensure R1 remained safe and without injuries. On 3/29/21 at 10:52 a.m., V4 (Certified Nurse Aide) stated R1 was very difficult to keep from getting up without assistance. V4 stated R1 was fast and due to his Dementia, R1 just didn't remember not to get up. V4 stated 1:1 supervision was not provided that V4 was aware of. On 3/29/21 at 10:55 a.m., V5 (Licensed Practical Nurse) stated R1 was always trying to get up and walk independently. V5 stated the staff would try to keep him in their eyesight when he was awake but as they went to take care of another resident, R1 would be trying to stand and often fall. V5 stated the staff were not able to provide 1:1 care for R1 because there were also other Dementia residents to care for. (B)	S9999		