STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING: _____ B. WING _____	C 04/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

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S 000	Initial Comments Complaint Investigations:2141919/IL132003	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	S9999		

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S9999	Continued From page 2 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. These Requirements were not met evidencdec by: Based on observation, interview, and record review, the facility failed to provide supervision and implement effective interventions for 1 of 4 residents (R2) reviewed for falls in the sample of 4. This failure resulted in R2 falling multiple times and sustaining a fracture to the right femur requiring surgical intervention. Finding includes: The Physician's Order Sheet (POS), dated 03/01/21, documented R2 was admitted to the facility with diagnoses of repeated falls, non-traumatic chronic subdural hemorrhage, dementia, Alzheimer's disease, glaucoma, chronic deep vein thrombosis, heart failure, anemia, obstructive sleep apnea and fracture of the neck of right femur (03/15/21). The Minimum Data Set (MDS), dated 02/11/21, documented R2 was severely cognitively impaired and required extensive assist of one person for bed mobility, transfers, dressing, toileting, hygiene, and bathing. It's documented R2 was frequently incontinent of bladder and	S9999		

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S9999	Continued From page 3 could only stabilize while standing with assist. On 03/30/21 at 12:40 PM, R2 was sitting in a wheelchair in a small room with a television and a bedside table in front of him feeding himself. He was alert, but confused. R2 had an alarmed seat belt attached around his waist. The personal alarm light was lit indicating it was on. V3, Licensed Practical Nurse (LPN) was sitting at the nurse's station behind R2, separated by a partial wall and the nurse's station itself. V3 stated R2 removes his seat belt a lot and the alarm sounds. On 3/30/21, at 2:55 PM, V1, Administrator, V2, Director of Nursing (DON) and V9, Registered Nurse/Unit Manager were observed to demonstrate the alarming seat belt on R2's wheelchair. V9 clipped the belt together after V2 had turned the device on. V9 then pulled the seat belt apart and the alarm sounded. When V2 pulled the cord from the device the alarm did not sound. V1 and V2 stated that R2 was a very fidgety person and moved around a lot and could have dislodged the alarm. V1, V2, and V9 could not answer why the device would not sound if the cord was removed. V1 and V2 could not answer if the alarm not sounding was due to the cord being disconnected, or malfunctioning. The Care Plan, dated 09/25/18, documented R2 was identified as being high risk for falls related to impaired mobility, history of self transferring with calling for assist, reports of feeling unsteady when walking or standing. R2's Care Plan intervention, dated 1/21/19 documented "bed alarm." R2's Care Plan Intervention, dated 3/6/19, documented "Alarming seat belt placed 2/11/19." R2's Physician's Order, dated 2/11/19 documented R2 was to have alarming seat belt	S9999		

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S9999	Continued From page 4 while up in wheelchair. On 02/12/20 at 3:03 PM, a Nurse's Note documented, "Writer was notified that resident was observed on the floor in his room while trying to transfer self. He was assessed on the floor, no injury noted at the moment, he denied having pain. He moved all extremities without difficulty. MD's (Medical Doctor) office and the POA (Power of Attorney) were notified about the fall. Neuro checks were started and will continue to monitor." There was no fall investigation presented by the facility. R2's Care Plan was not revised with a progressive intervention to address this fall and to prevent him from having future falls. On 04/13/20 at 3:41 PM, a Nurse's Note documented, "Resident was observed on back laying on ground (floor mat) on side of bed. Resident was observed wearing socks. Denies hitting head. Neurological assessment performed. Vitals obtained. When asking resident what happen, resident stated "I was trying to get up to make some coffee." Resident was assisted by staff back into bed." The Occurrence Report documented the alarm was not sounding. The Occurrence Report documented the recommendation as "check bed alarms q (every) shift to make sure working properly." R2's Occurrence Report, dated 06/23/20 at 10:00 AM, documented, "Resident propelling self down the hall and took seatbelt off and stood up and fell on his side. Writer assessed resident he has two skin tears to left hand in-between his thumb, and pointer finger. Resident able to perform ROM (Range of Motion) WNL (Within Normal Limits)." The Report documented the following recommendation for this fall "Referral to therapy for evaluation."	S9999		

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S9999	Continued From page 5 On 6/26/20 at 3:43 AM, a nurse's note documented R2 was found walking in the hallway independently and redirected back to bed. There was no documentation if an alarm was sounding. On 7/23/20 at 7:00 PM, a Nurse's Note documented, "Resident found on floor by laying on floor by door. Resident unsure of why he got up when asked by writer. Writer assessed resident no injuries at this time. Resident able to perform ROM WNL. Resident reminded to use call light at all times. MD, and POA called, and Neuro checks initiated." The Occurrence Report, dated 7/23/20, documented no alarm sounded when R2 fell. The Occurrence Report Recommendation documented "frequent rounding." There was no documentation on R2's Care Plan that the facility revised this care plan with progressive interventions after R2 fell on 7/23/20. On 2/3/21 at 3:34 AM, a Nurse's Note documented, "Resident found sitting on his bottom in the room's doorway, on the floor. Bed alarm on but not sounding. Assessed resident. Staff helped resident into wheelchair. Bruise noted to left forehead area. MD, and POA notified. Fall, and Neuro checks in place." The fall investigation documented R2's alarm was not sounding, and the bed alarm was replaced. R2's Care Plan Intervention, dated 2/3/21, documented that R2's bed alarm was replaced. On 03/15/21 at 7:20 PM, a Nurse's Note documented, "Writer was notified by housekeeping staff that resident was on the floor, upon assessment resident observed sitting on his	S9999		

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buttocks with back against the door of the 400 hall common area. Alarm wasn't sounding. I immediately noticed his right leg was inverted inward and he was complaining of pain to right hip/leg. I also observed a dime sized abrasion to left side of his head, with a small amount of blood coming from it." Nurse's note documented R2 was sent to the emergency department via ambulance with the diagnosis of fracture of the right femoral neck.

R2's Hospital Record, dated 3/16/21 documented R2 had a fall and sustained a right femoral fracture. The Hospital Record documented "Plan for pinning of the right femoral neck fracture today (3/16)."

The bed and seat belt chair alarm checks were reviewed for the months of February, and March 2021. There were multiple days with missing documentation of the alarms not signed off as being checked per shift as ordered. On 03/19/21 and 03/21/21, the self releasing alarm was documented as being checked and functioning when the resident was still in the hospital.

R2's Care Plan, revision date 3/30/21, documented "(R2) disassembles his alarms at times due to constant fidgeting."

On 03/30/21 at 10:20 AM, V1, Administrator stated R2 had a history of falls and recently fell and fractured a hip. V1 stated "he was a confused resident and required full assistance with Activities of Daily Living. V1 stated R2 can propel himself in his wheelchair and liked to keep a blanket up over his head most of the time. V1 stated R2 cannot answer questions appropriately and was confused most of the time. V1 stated R2 had fallen in the past with no injury and had

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multiple interventions in place at the time of this last fall. V1 continually stated that on 03/15/21, the alarm had been heard by multiple staff sounding due to R2 continuously removing the seat belt".

On 03/30/21 at 10:30 AM, V2, Director of Nurse's (DON) stated R2 was always a "busy body" and would propel himself everywhere in the facility. V2 stated R2 was confused and could not let his needs be known at times. She stated that R2 had several interventions in place for falls".

On 03/30/21 at 12:40 PM, V3, Licensed Practical Nurse (LPN) stated she "did not have R2 on her hall currently, but knew he was very active while up in his chair. V3 stated staff try to keep an eye on him as much as possible. V3 stated R2 does undo the seat belt often and the alarm sounds".

On 03/30/21 at 2:55 PM, V9, Registered Nurse (RN) stated "R2 was always propelling self about the facility and liked to go into other's rooms at times. She stated R2 was known to remove the seat belt and it always sounded".

On 03/31/21 at 10:05 AM, V6, Certified Nursing Assistant (CNA) stated on 03/15/21 at the time R2 fell, she was "in another resident's room giving a bed bath. She did not witness the fall". She stated that R2 was acting his usual self that evening before the fall. V6 stated R2 sometimes gets anxious and propels fast down the halls and runs into things and people and goes into other resident's rooms. V6 stated about 45 minutes to 1 hour before the fall she toileted R2 and put him back into his wheelchair. V6 stated she was told R2 was down on the floor by the library. She stated there were no staff down there when he fell. V6 stated during that time of the night, staff

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S9999	Continued From page 8 are very busy with putting residents to bed". She stated "that night they were short staffed. She stated they normally have 2-3 CNA's and one nurse on the evening shift and that night they only had 2 CNA's. She believed the other CNA was on break at the time of the fall. She stated R2 plays a lot with the seat belt, but she stated she had not seen or heard it not alarm. She stated R2 needed one on one more often, but they don't have the staff to do that. She stated R2 will sometimes fall asleep in the chair and they will lay him down, but he will sometimes try to get out of bed afterwards. She stated R2 needed more supervision at times, but that was impossible with the amount of staff they have on most shifts. She stated R2 cannot use a call light due to his cognitive deficit". On 04/01/21 at 2:00 PM, V8, RN stated she "had only worked with R2 after he returned from the hospital with the fractured hip. She stated R2 tries to get up/stand up all the time. She stated R2 removed the seat belt a lot. She stated it was physically impossible for staff to watch R2 at all times. V8 stated when R2 is up in the wheelchair he is all over the place. V8 stated staff will try to keep him in their field of view, but they can't watch him at all times. V8 stated R2 would benefit from one on one from staff, but they do not have the staff to do that. She stated she had not heard or seen R2's alarm fail. She stated R2 does not use his call light due to his cognitive deficits". The manufacturer's guidelines titled, "(Proper Name of Seatbelt) Alarmed Velcro Seatbelt Installation Instructions" was reviewed. It documented "The alarm box features a fail-safe circuit. In the event that the cord is accidentally removed while the unit is on, the alarm will sound."	S9999		

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S9999	Continued From page 9 The manufacturer's guidelines titled, "Drive Sensor Basic Alarm: Tamper-proof chair and bed patient alarm - Item #13605" was reviewed. It documented "This device is not a substitute for routine visual monitoring of patients. It will not prevent falls. Staff must make frequent routine visual inspections to ensure sensor pad is properly placed and alarm unit is powered on. Use of alarm unit may not be suitable for all "High risk" patients. Other safety measures may still be necessary to ensure patient safety." The policy and procedure titled, "Fall Prevention - Steady Steps," revision date 2/17/2020, was reviewed. It documented under policy "It is the policy of the facility to provide each resident with an appropriate assessment and intervention to prevent falls and to minimize complications if a fall occurs." Under Fall Prevention it documented, "Residents identified as at risk for falls, will have clinically appropriate interventions put into place to reduce the risk for falls and/or to prevent recurrence of falls." " A"	S9999		