

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005748</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/03/2021</b>
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NAME OF PROVIDER OR SUPPLIER <b>MAR KA NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 SOUTH 10TH STREET MASCOUTAH, IL 62258</b>
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(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 #2147871/II139544 Complaint #2147795/IL139442	S 000		
S9999	Final Observations  Complaint #2147871/II139544 Complaint #2147795/IL139442  STATEMENT OF LICENSURE VIOLATIONS:  300.610a) 300.610c)4)F) 300.1210d)6) 300.1220b)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 300.610 Resident Care Policies  c) The written policies shall include, at a minimum the following provisions: 4) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated	S9999		

Attachment A  
Statement of Licensure Violations

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Illinois Department of Public Health

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**MAR KA NURSING HOME**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**201 SOUTH 10TH STREET  
MASCOUTAH, IL 62258**

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S9999	<p>Continued From page 1</p> <p>with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident; and</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>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</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>These Regulations were not as evidenced by:</p> <p>Based on observation, interview and record review, the Facility failed to identify residents at risk for falls, provide safe transfers, implement effective/progressive fall prevention interventions, determine the root cause of falls, and follow the Facility Fall Prevention Policy for 3 of 3 residents (R1, R2, R4) reviewed for falls in the sample of 9. These failures resulted in R1's fall sustaining a skull fracture and brain bleed; R2's fall sustaining a right distal femur fracture and left periprosthetic femur fracture both requiring surgical intervention and hospitalization.</p> <p>Findings include:</p> <p>1. R2's Minimum Data Set (MDS) dated 10/18/21 documents that R2 is severely cognitively impaired and requires two assist for transfers and is totally dependent on staff for bathing.</p> <p>R2's Progress Notes dated 10/23/21 documents, "CNA came to this nurse stating that when transferring resident from wheelchair to shower chair, balance became unsteady so she lowered resident to the ground. Resident did not hit her head."</p> <p>On 10/28/21 at 1:50 PM, V10, CNA (Certified Nursing Assistant), stated, "I only heard rumors of what happened. (R2) fell during a transfer during her shower. The CNA said she lowered her to the ground. It seems odd that if she was lowered to the ground, how did she get that hurt?"</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>On 10/28/21 at 2:49 PM, V13, Care Plan Nurse, confirmed that R2's Care Plan did not address R2 as being a Fall Risk, nor list any fall prevention interventions.</p> <p>On 10/28/21 at 2:50 PM, V13, CNA, was being interviewed by V1, Administrator, for the fall investigation report. At this time V13 stated, "(R2's) fall happened on a Saturday. I was giving her a shower. I was in the room the whole time. I should have put a blanket down because the floor was wet. I did not use a gait belt. I got her pants halfway down when one of her legs went in between mine and the other one slid the other way. (R2) did complain of knee pain when I stretched it out. (R2) said, "I think my leg is broken." It looked like the knee cap went to one side and there was swelling on the other side. (R2) is normally one assist. I am not sure what fall interventions are in place."</p> <p>On 11/1/21 at 3:00 PM, R2 was observed lying in bed. The bed was not in the lowest position and could be lowered further. There was no fall mat present. R2 did not have socks on.</p> <p>On 11/2/21 at 1:15 PM, the report sent to the Illinois Department of Public Health (IDPH), that had previously been requested on 11/1/21, was provided. The report was titled, "Summary of Findings to Reportable Injury 10/23/21." It documents that V13 was transferring R2 from her wheelchair to the shower chair, V13 held onto the back of R2's pants, and that due to loss of balance and a wet floor, V13 lowered R2 to the floor. It further documents that X-rays were ordered for R2's bilateral knees which revealed a distal femur fracture to the right leg. It does not mention the fracture to the left femur. The</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>documents lists placing non-ski strips in the shower to prevent falls due to wet floors as an intervention.</p> <p>On 11/2/21 at 1:30 PM, V15, Licensed Practical Nurse (LPN), stated that R2 uses the shower on her hall. At this time, the shower room on the hall which R2 resides on was observed. There were no non-skid strips in the bathroom by the showers or the toilet. This observation was verified and confirmed with V2, Director of Nursing (DON).</p> <p>On 11/2/21 at 1:45 PM, V18, Nurse Practitioner (NP) stated, "(R2) used to use her legs/arms well and was able to wheel herself around in chair. If they were not using a gait belt and she slipped in water, that's not safe. It absolutely caused her harm if she's got broken bones now."</p> <p>R2's metropolitan hospital Encounter Information, dated 10/29/21, documents Admission 10/24/21 to Geriatric Trauma Surgery Team, Discharge 10/29/21. It also documents R2 had a right distal femur fracture and a left periprosthetic femur fracture both requiring surgical interventions.</p> <p>2. R1's Care Plan documents, "(R1) has a potential for falling related to fall history, cognitive impairment, non-compliance with safety needs and high-risk medications.</p> <p>The Facility's Incident/Accident Log dated October 2021, documents an incident resulting with a laceration on 10/14/21.</p> <p>R1's Progress Notes dated 10/14/21 at 9:53 PM documents, "This nurse was called over to (R1's) table in dining room. (R1) was on the ground. Per CNA resident stood up and lost her balance. Resident was assessed for injury and helped</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>back into dining room chair. Area to head was cleaned and dressing was applied. POA (Power of Attorney), nursing management and Nurse Practitioner notified."</p> <p>R1's Progress Notes dated 10/15/21 at 10:38 AM documents, "IDT (Interdisciplinary Team) met to review event from 10/14/21 when resident had a witnessed fall resulting in a superficial laceration to the back of the head." It continues to document, "Fall assessment updated and continues to show resident at high risk for falls. Root cause determined to be increased behaviors requiring redirection that resulted in resident losing her balance. SS (Social Services) to contact psych to have medications reviewed.</p> <p>R1's Care Plan does not reflect a intervention being implemented after the fall that occurred on 10/14/21.</p> <p>R1's Progress Notes dated 10/27/21 at 8:07 AM documents, "CNA alerted the nurse that (R1) was having a hard time ambulating and was complaining of pain. Upon assessment, it was noted that the right hip looked like it was rotated inwards and (R1's) right knee was more swollen than the left knee. The nurse practitioner ordered STAT (Immediately) x-ray of right hip/femur."</p> <p>The Facility never provided the X-ray results, although, they were requested multiple times.</p> <p>On 10/28/21 at 12:45 PM, R1 was lying on her back on the floor in her room. R1 was complaining of pain. V9, LPN, V10, CNA, and Emergency Medical Technicians were present in the room. R1 was heard complaining of pain and there was blood on the pillow beneath R1's head.</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>On 10/28/21 at 1:15 PM, V10, CNA, stated, "(R1's) fall was unwitnessed. I found her, laying on her back on the floor when I delivered her tray. She cried out when we tried to move her. She said her back, head and hip hurt. I heard just (R1) also had a fall on the 14th (10/14/21). There are no fall interventions in place. She is in a low bed though."</p> <p>R1's Progress Notes dated 10/29/21, documents, "Call placed to (local hospital) to see what resident was admitted with. Spoke with nurse who said resident was admitted with a subdural hematoma, subarachnoid hematoma and a skull fracture. (Nurse) also said family is considering hospice."</p> <p>On 11/2/21 at 9:30 AM, V10, CNA, stated, "I had last seen her a little bit before her fall. She was up ambulating in the hall. She was not in bed when I saw her last."</p> <p>On 11/2/21 at 10:00 AM, V3, Social Services, stated, "I did contact psych. That was one of the interventions for her falls, which I think is ridiculous. They said keep her meds the same. I contacted them on 15th. She has not had any med changes recently, they were working."</p> <p>The Facility never provided a fall investigation or any report sent to IDPH regarding this fall and the outcome of it.</p> <p>3. The Facility's September and October Incident/Accident Reports document several incidents/accidents involving R4.</p> <p>R4's Progress Notes dated 9/28/21 documents, "Called to residents room and found resident on floor next to bed. The bed was deflated at the</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>time. Unknown how that happened. Was assisted back to an inflated bed with 3 assists."</p> <p>R4's Progress Notes dated 9/29/21, documents, "IDT met to review event from 9/28/21 when resident was found on the floor of the room beside her bed. Investigation shows resident has diagnoses of CVA, aphasia, hemiplegia/hemiparesis, weakness and osteoarthritis. Fall assessment shows resident to be at high risk for falls. Initial inspection of the environment shows air mattress was unplugged and deflated. Upon further review, it was noted the position of the bed blocks the room door from being opened fully. Because of this the bed is frequently moved and could easily cause the plug to be pulled out. Bed has been repositioned against the wall to allow better access to a clutter free environment. Resident did not receive injuries. Neuros have been WNL (within normal limits). Care plan reviewed and updated."</p> <p>R4's Progress Note dated 10/14/21 at 1:27 PM documents, "Resident had a fall on 9/28/21 when she rolled out of bed. Interventions implemented have been effective."</p> <p>R4's Progress Notes dated 10/20/21 documents, "IDT met to review event from 9/28/21 when resident fell from bed. Previously implemented interventions have been effective. No new recommendations at this time."</p> <p>R4's Progress Notes dated 10/30/21 at 4:30 PM documents, "Was called to room (#) by roommate and found resident on the floor leaning against the bed. Resident unable to say what happened. Left side of air mattress was deflated and it appears that resident slid out of bed. No injuries noted. Resident put in WC (wheelchair) and</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>brought to the Dining room to monitor. Neuro checks started."</p> <p>On 11/3/21 at 1:45 PM, V2, DON, stated, "If they haven't sent you the investigations related to the falls by now, they don't have them."</p> <p>The Facility's Fall Prevention Policy dated 2/2021 documents, "Following any falls, facility staff will complete an Occurrence Report. Details of the fall will be reported and potential causal factors identified and investigated. Interventions will be implemented following each fall and added to the residents plan of care."</p> <p>(A)</p>	S9999		