STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003933	A. BUILDING: _____ B. WING _____	C 11/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALLMARK HEALTHCARE OF PEKIN	2501 ALLENTOWN ROAD PEKIN, IL 61554

(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 2128801/IL140712	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)6) 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. 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 nursing personnel shall evaluate residents to see	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on interview and record review the facility failed to prevent a resident from falling off the bed during cares for one of three residents (R1) reviewed for falls in a sample of three. This failure resulted in R1 sustaining a left intertrochanteric hip fracture. Findings include: R1's Fall Risk Assessment dated 9/7/21 documents that R1 is at high risk for falls because of being chairbound and/or requiring assist with elimination, legally blind, unable to stand, and is being administered three to four medications which put R1 at high risk for falls. R1's current care plan documents that R1 is at risk for falls related to weakness with a goal to limit or minimize R1's risk for falls and injuries, may require one or two person assist with repositioning in bed depending on the resident's condition. R1's care plan also documents that R1 has been exhibiting increased confusion. R1's Minimum Data Set (MDS) assessment dated 10/7/21 documents R1 has highly impaired vision, requires extensive assistance of two people for bed mobility, is totally dependent on two staff for toileting which includes cleansing after elimination, changing incontinence pad, adjusting clothing. On 11/29/21 at 1:55p.m. V7 (R1's Power of Attorney/POA) stated that on 11/26/21 R1 fell off	S9999		

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S9999	Continued From page 2 the bed while receiving incontinence care from a CNA (Certified Nurse Aide) at the facility. V7 stated that R1 sustained a fractured hip which required surgery as a result of this fall. R1's nurse's note dated 11/26/21 at 11:09p.m. and entered by V4 (Licensed Practical Nurse/LPN) documents, "CNA was doing peri care on resident and when resident was rolling over to be changed her left leg went forward too far and she rolled out of bed onto the floor, resident landed on her left side." R1's nurse's note dated 11/27/21 at 1:43p.m. and entered by V5 (Registered Nurse/RN) documents that X-ray results showed that R1 had sustained a left hip fracture and was transferred to the hospital for treatment. R1's X-ray report dated 11/27/21 documents that R1 sustained an acute left intertrochanteric hip fracture. On 11/29/21 at 6:21p.m. V3 (CNA) stated she was R1's CNA the night she fell out of bed on 11/26/21. V3 stated on 11/26/21 sometime between 7:00p.m. and 8:00p.m. V3 entered R1's room to see if R1 had been incontinent and R1 needed changed. V3 stated that even though R1 was sound asleep, V3 told R1 that she was going to check to see if she needed changing. V3 stated that she pulled back R1's covers and saw that R1 had been incontinent of urine and needed a complete bed change and clothing change. V3 stated that she told R1 that she needed changing, but R1 was "mostly asleep and didn't answer." V3 stated, "I rolled (R1) toward her window. I noticed she can hold herself up on her side from when I have cared for her before. She had been on her side for a good five minutes when I turned away for a split second and when I turned back R1 had	S9999		

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S9999	Continued From page 3 adjusted one leg and fell out of bed." V3 stated when the nurse assessed R1, R1 didn't complain of pain or have any signs that she had any broken bones but later during the night R1 began to complain of left leg pain. V3 stated that V4 (LPN) called R1's physician for orders for an X-ray which showed R1 had a fractured left hip. V3 stated, "I think if I had had my hands on (R1) she may not have fallen out of bed." V3 stated that if she had kept her hands on R1 instead of turning away, she might have felt R1 shifting in the bed and prevented her from falling off the side. On 11/30/21 at 11:40a.m. V2 (Director of Nurses/DON) stated that R1's fall from the bed resulting in a left hip fracture was avoidable because V3 turned away from R1 without maintaining physical contact despite knowing that R1 was very sleepy and not verbally responding when V3 turned R1 to her side in the bed. (A)	S9999		