STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012470	A. BUILDING: _____ B. WING _____	01/06/2022

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Annual Licensure Recertification STATEMENT OF LICENSURE VIOLATIONS: 300.610c)4) 300.1210a) 300.1210b) 300.1210d)6) 300.1220b)3) 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 with the lifting, transferring, repositioning, or movement of a resident. The policy Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. Section 300.1210 General Requirements for Nursing and Personal Care 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: 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,	S9999		

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S9999	Continued From page 2 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. These regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to assess and identify causative factors contributing to falls, develop progressive interventions based on identified factors, and monitor and modify those interventions when needed for 4 of 8 residents (R10, R14, R28, R52), reviewed for falls in a sample of 30. This failure resulted in R52's falling and sustaining a laceration to the head requiring six staples. Findings include: 1. R52's Minimum Data Set (MDS), dated 12/14/21, documented, a medical diagnosis of Dementia, Laceration to scalp prior to admission of 2/28/20, abnormal posture, pain in right knee, lack of coordination, muscle wasting, repeated falls, unsteadiness on feet and severe mental cognition. The MDS documented R52 requires assistance of one staff member for transfers, walk in room, walk outside of room and toilet use. R52's MDS documents R52's balance during transition and walking as not steady and requires staff to assist with moving from seated to	S9999		

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S9999	Continued From page 3 standing position, walking, turning around, moving on and off toilet and transfer between bed and chair or wheelchair. R52's Observation Report, Under Section entitled Fall Risk Assessment Tool, dated 6/29/21 and quarterly assessment dated 9/27/21, documented R52 was at High Risk for Falls. R52's Care Plan, dated 2/28/20, documented at risk for falling due to weakness, decreased mobility, glaucoma, muscle weakness, dementia, unsteady on feet and repeated falls. R52's Care Plan Approach dated 2/28/20 documents "Call light in reach". R52's Care Plan Approach dated 5/11/20, documents "Provide proper, well-maintained footwear". R52's Care Plan Approach, dated 10/16/20 documents "Alternate call light." R52's Event Report (Fall Occurrence), documented R52 had falls on the following dates: 1/19/21, 3/15/21, 5/11/21, 6/5/21, 6/23/21, 7/1/21, 8/29/21. R52's Event Report, dated 1/19/21, documented R52 52 fell in her room. The Report documented it was an unwitnessed fall. The Event Report documented that immediate measure taken to address R52's fall was "Alternate call". The Event Report documented the following Progress Note dated 1/19/21 "Staff states resident was observed on bottom on the floor and resident states she was trying to get to the bed and 'went down'. Prior to fall resident was up in wheelchair reading a magazine with call light in reach. Resident was assessed with no injuries, ROM (range of motion) to all 4 extremities without complication, and no new skin issues noted. Resident VS (Vital Signs) WNL (Within normal	S9999		

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S9999	Continued From page 4	S9999		

limits). Resident encouraged to use call light for staff assistance when transferring and ambulation."

There was no documentation on R52's Care Plan that the facility implemented any new interventions to address R52's fall on 1/19/21. R52's Care Plan had no documentation of revisions related to this fall.

R52's Event Report, dated 3/15/21, documents R52 had an unwitnessed fall in her room. The Event Report documented R52 stated she slid from the bed. The Event Report documented the immediate measures taken were "rest and "increased toileting."

R52's Care Plan Approach, implemented on 3/15/21 documents "Encourage (R52) to use environmental devices such as hand grips, hand rails, etc." There was no documentation on this Care Plan related to increased toileting or increased supervision to prevent R52 from future falls.

R52's Event Report, dated 5/11/21, documented R52 had an unwitnessed fall in her room. The Event Report documented R52 stated she lost balance and fell. The Event Report documented there were no immediate measures put into place after this fall. The Event Report under Section "Notes" documented the following Progress Note: "Resident observed on floor in her room ear bathroom. Resident stated that she had just finished using the bathroom and walked out of the bathroom leaving her walker in the bathroom adding that she lost her balance and 'fell'. Resident denied hitting her head with no injury noted. ROM WNL x 4 extremities. No rotation or shortening noted. Resident did receive a 2 cm

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S9999	Continued From page 5 (centimeter) x (by) 3 cm skin tear to her right elbow and a small amount of blood. Area around skin tear staring to bruise and is purplish in color. Area Cleansed. Two steri-strips applied. Noted a small reddish abrasion to inner right wrist area. R52's Care Plan Approach, dated 5/11/21 documents "Give verbal reminders to use walker with ambulation." R52's Event Report, dated 6/5/21, documents R52 was outside in the courtyard with family and fell. The Section "Notes" documented the following Progress Note "Called by family to courtyard when resident lost balance and was assisted to the ground by family." R52's Care Plan Approach, implemented on 6/8/21, documents "observe frequently." The Care Plan approach did not specify as to how frequently staff should observe R52. R52's Event Report dated 6/23/21, had no immediate interventions listed or where this fall took place. R52's Progress Note, dated 6/23/21 at 10:46 PM, documented Resident observed on floor at 7:15PM, laying slightly on her right side at the foot of her bed with head near door. Observed active red drainage from the back of residents head and on the floor." The Progress Note documented that R52 was sent via ambulance to a local hospital Emergency Room. R52's Progress Note, dated 6/23/21 at 10:51 PM documented R52 received six staples to a laceration at the back side of her head and would be returning to the facility.	S9999		

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S9999	Continued From page 6 R52's Care Plan was not revised after this fall to include progressive interventions to address R52's fall and prevent her from future falls. R52's Event Report documented that on 6/30/21 at 12:56 PM, R52 fell in her room. The Report documented that R52 stated she was ambulating to the bathroom and her feet got caught and "I went down." The Report documented the immediate interventions implemented were rest, ice and "increased toileting." R52's Care Plan was not revised after this fall to include progressive interventions to address R52's fall on 6/30/21 and prevent her from future falls. R52's Event Report documented on 8/29/21, R52 had an unwitnessed fall in her room. The Report documented she was near closet without her walker and lost her balance. The Report documented she sustained a skin tear measuring 0. 5 cm on her right-hand 5th knuckle. The Report documented the immediate interventions implement were "rest". R52's Care Plan was not revised after this fall to include progressive interventions to address R52's fall on 8/29/21 and prevent her from future falls. On 1/3/22 at 10:35 AM, V1, Administrator, stated the facility does not have a Care Plan and MDS Coordinator, and for now the Interdisplinary Team is working on the Care Plans and MDS charting. On 1/5/22 at 2:45 PM, V2, Director of Nursing (DON), stated she would expect with each fall occurrence, a new fall intervention should be documented and previous falls to be monitored of	S9999		

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S9999	Continued From page 7 the effectiveness. On 1/6/22 at 3:00PM, V1 stated she would expect that R52 should be observed closely. On 1/6/22 at 9:50AM, V17, Certified Nurse Aide, stated that R52 has her moments of being in bed all day to up all day. 2. R10's, Face Sheet, undated, documented R10 had diagnoses of unspecified dementia, repeated falls, active seizures and insomnia. R10's Care Plan, initiated on 1/15/2020, documents R10 is at risk for falling related to dementia, seizure activity, dx (diagnosis) of other lack of coordination, and difficulty walking, not elsewhere classified. R10's, MDS, dated 10/6/21, documented, severely impaired cognition, incontinent of bowel and bladder and assistance of two staff with all R10's care needs. R10's Observation Report (Fall Risk Assessment), dated 7/5/21, documented R10 at high risk for falls. The facility failed to complete a following quarterly Fall Risk Assessment. R10's Event Report, dated, 5/24/21, documented an un-witnessed fall in the dining room at 7:32AM, with seizure activity to follow, this injury resulted in receiving 2 staples to the head and without a fall intervention documented. R10's Event report, dated 10/22/21, documented R10 had an un-witnessed fall, located in hallway. The Event Report documented R10 had a reddened area noted on her mid back.	S9999		

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S9999	Continued From page 8 There was no documentation in R10's Care Plan that the facility implemented progressive interventions to address R10's fall on 10/22/21. R10's Event Report, dated 12/13/21, documented R10 had witnessed fall, with no injury. The Report documented no immediate intervention to address this fall. There was no documentation in R10's Care Plan that the facility implemented progressive interventions to address R10's fall on 12/13/21. R10's Event Report, dated 12/27/21, documents R10 had a fall in her room. The Report documented she had a red mark on her right shoulder. The Event Report documented no immediate intervention to address the fall. There was no documentation in R10's Care Plan that the facility implemented progressive interventions to address R10's fall on 12/27/21. 3. R14's Face Sheet, undated, documented a medical diagnosis of; dementia, fracture of left femur, closed for healing (history of), altered mental status, need for assistance with care, unsteadiness on feet, lack of coordination and repeated falls. R14's Care Plan, dated 4/02/20, documents R14 has a risk for falls related to diagnoses of dementia, pain, anxiety, unsteadiness of feet, polyuria, muscle weakness and atrophy, lack of coordination and psychotropic medication use. R14's Care Plan Interventions are as follows with the following implementation dates: 12/14/2020, "Observe frequently and place in supervised area when out of bed"; 1/12/21, "Monitor and assist more frequently for toileting needs through the	S9999		

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S9999	Continued From page 9 day"; 1/17/21, "Occupy resident with meaningful distractions: activities of interest"; 6/8/21, "Encourage resident to use environmental devices such as hand grips, hand rails, etc."; 8/25/21, "Provide toileting assistance every 2 hours and PRN (as needed)" and "Give resident verbal reminders not to ambulate/transfer without assistance." R14's MDS, dated 10/12/21, documented, severe mental cognition, assistance of two staff for all care needs, frequently incontinent of bowel and bladder and unsteady with balance during transitions and walking requires staff assistance. R14's, Observation Report (Fall Risk Assessment), dated 7/31/20, documented a high risk for falls. The facility failed to complete quarterly fall assessments. R14's Event Report, dated for the following fall occurrences; 8/21/21, 8/22/21, 10/19/21 and 10/6/21. R14's Event Report documented on 8/21/21, R14 was sitting in a chair in room and fell. R14's Event Report, dated 8/22/21, documents R14 was sitting in a chair in room and fell. R14's Event Report, dated 10/6/21, documents R14 fell in the dining room. The Event Report documented under Section "Notes" the following: "Resident was sitting at table during breakfast and slid out of her chair on to the floor." R14's Event Report, dated 10/19/21, documented R14 was in the day room and found laying on the floor in front of the recliner with her wheeled walker beside her. The Event Report documented	S9999		

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S9999	Continued From page 10 she sustained a skin tear to her right outer elbow. R14's Care Plan was not updated with progressive interventions to prevent falls after R14 fell on 10/6 and 10/19/21. The facility failed to present a Fall Prevention Policy and Procedure. On 1/6/22 at 2:30 PM, V2, Director of Nursing, stated that V1, Administrator had confirmed that the facility does not have a Fall Prevention Policy. 4. On 1/6/22 at 1:40 PM, R28 was observed in her recliner sleeping. R28's call light was not within her reach. The call light was clipped to the privacy curtain. R28's Face sheet, not dated, documents R28's has diagnoses of Low Back Pain, Chronic Pain, Abnormal Posture, Repeated Falls, Altered Mental Status, Difficulty Walking, Muscle Weakness, Unsteadiness on Feet, Muscle Wasting and Atrophy and Osteoarthritis. R28's Care Plan with a start date of 1/28/21 documents, "PROBLEM: (R28) is at risk for falling related to (R/T) generalized weakness, osteoporosis, sciatica and will put herself on the floor." The following are R28's Care Plan Interventions and the dates they were documented as initiated: 01/28/2021, Therapy to eval and treat as ordered; 02/15/2021,Keep call light in reach at all times and attach it to wheelchair/recliner/bed; 03/03/2021, Dycem applied to seat of wheelchair; 05/10/2021, Keep personal items and frequently used items within reach; 06/29/2021, Take resident to restroom often. Take resident to restroom when signs or symptoms of needing to void; 07/22/2021,	S9999		

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S9999	Continued From page 11 Provide proper, well-maintained footwear; 07/31/2021, Observe frequently and place in supervised area when out of bed; 08/05/2021, Occupy resident with meaningful distractions: social and independent activities, offer to call her daughter, watch television program of choice; 08/25/2021, Assure resident is wearing eyeglasses. Assure eyeglasses are clean and in good repair; 08/30/2021, Give resident verbal reminders not to ambulate/transfer without assistance. R28's MDS dated 10/19/21 documents, R28 requires two-person physical assistance with transfers. The MDS documents R28 walks in room and needs extensive assist of two-person physical assist. R28's MDS documents R28 has severe cognitive impairment. The MDS documents R28 is unsteady and only able to stabilize with staff assistance with moving from seated to standing position, walking, turning around, moving on and off toilet and during surface to surface transfers. The facility Accident and Injury Reports from 9/2021 through 12/2021 documents R28 has had 11 falls in 4 months. R28's Event report dated 9/6/21 at 12:00 PM documents, "Laying on right side on floor in front of w/c (wheelchair). Complains of pain right hip, right upper rib cage and right upper back." R28's Progress Note dated 9/06/2021 12:30 PM, documented new orders (N.O) for Xray of right hip, upper right rib cage, upper mid right back, and right hip. R28's Progress Notes dated, 09/07/2021 at 1:16 AM, documents "Xray reports received and faxed	S9999		

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to Doctor. Reports state that rt rib views show multiple healed rib fracture (fx) on right, osteopenia, and pleural apical plaque identified. Impression chronic changes. Thoracic spine, T12 and L1 compression deformities, age undetermined. Rt hip no acute fx or dislocations noted. Osteopenia. Res. (Resident) has been in bed this shift. Resting quietly. No c/o (complaints of) or s/s (signs and symptoms) of pain or discomfort noted. (R28) took Tylenol this pm without (w/o) issue. Small scab continues about right ear. No s/s of infection noted. Discolored areas with small scabs continue on bilateral lower legs."

R28's Care Plan Intervention, revised on 09/07/2021, documents "Encourage resident to use environmental devices such as hand grips, handrails, etc."

R28's Progress Notes dated 09/08/2021 at 7:30 PM, documents "(R28) was sitting in recliner yelling 'hey'. When going to room resident slid out of her recliner to the floor, couldn't get in room fast enough to stop resident from sliding all the way to the floor. Resident assisted up and into bed. No injuries noted. Resident had been complaining of back pain prior to incident. She would not sit in wheelchair properly and so she was assisted to bed. Resident did refuse her routine pain medication even after education given. Currently she is resting quietly in bed. Will continue to monitor."

R28's Care Plan Intervention, dated 09/09/2021, documents "Apply dycem to recliner."

R28's Progress Note, dated 09/15/2021 at 12:23 PM, documents "(R28) observed on floor by staff. Resident stated she had mild back pain, but no

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new areas or concerns noted at this time. Resident stated she was trying to get from her wheelchair to her recliner. Neuro WNL. VS 97.9 Pulse 82 RR (respiration) 20 O2 (oxygen saturation levels) 96% on RA (room air) BP (blood pressure) 134/62. MD notified and POA contacted to make aware of recent event."

R28's Care Plan Interventions, dated 09/16/2021, document "Reeducate resident safety measures: wait for assistance before transferring, ensure wheels are locked on wheelchair and that help is present before standing."

R28's Progress Note, dated 9/17/2021 at 1:39 PM, documents "(R28) observed on floor in bedroom to the side of her wheelchair, resident states 'I want in my chair', skin tear to left shin 3cm by 0.5cm steri strips applied, skin tear to left middle finger 2cm by 0.2cm steri strips and band aid applied, Right upper arm bruise 8 cm by 4 cm, hematoma to middle top forehead 5.5 cm by 4.5cm raised 0.5cm, Neuro are within normal limits, Resident does complain of back pain no injuries noted to back area, no shortening/deformity, ROM x4. medical doctor (MD) fax, POA called and left message."

R28's Progress Note, dated 09/20/2021, at 3:56 PM, "(R28) observed on floor in room, no injuries noted, no shortening/deformity, ROM x4, neuros within normal limits. Resident states "I slid out of my chair" resident cannot tell what chair she was in when she slid out."

R28's Care Plan Interventions, dated 09/20/2021, document "Call don't fall reminder sign within resident's sight in room" and "Assist resident from wheelchair to recliner after toileting immediately after meals unless resident chooses to self propel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012470	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PITTSFIELD MANOR	610 LOWRY STREET PITTSFIELD, IL 62363

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S9999	Continued From page 14 in her wheelchair." R28's Care Plan Intervention, dated 09/22/2021, documents "Continue therapy to work on positioning in wheelchair and strengthening as needed." R28's Event report dated 9/27/21 documents at12:50 PM R28 was found in front of recliner. R28's Progress Note, dated 10/02/2021 at 06:14 PM, documents "Resident was observed on the floor in her room. S/T to left knee cap. Edges well approximated, area cleansed and steri strips applied. POA was called and message left. MD was faxed." R28's Care Plan was not revised after R28 fell on 10/2/21 with progressive interventions to prevent her from falling in the future. R28's Progress Notes dated 10/04/2021 at 06:00 PM documents "(R28) observed on floor in room by doorway, room was clean and uncluttered, wheelchair was by recliner, hematoma 3.5centimeter (cm) by 4 cm raised 1cm in middle forehead, middle of hematoma has a skinned area, slight bleeding noted, band aid applied so resident does not pick at area, neuros within normal limits, no shortening/deformity noted to extremities, ROM x4 resident states 'I was getting in my chair' resident educated to use call light. MD aware POA made aware." R28's Care Plan was not revised with progressive interventions after R28 fell on 10/4/21 to prevent her from falling in the future. There was no progressive interventions related to R28's need for increased supervision.	S9999		

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S9999	Continued From page 15 R28's Progress Note, dated 10/10/2021 at 08:00 PM, documents "Received call from Registered Nurse (RN) at hospital. States (R28) will be returning to facility. CT of head negative. States liquid dressing applied to laceration at upper forehead. Skin Tear (S/T) at forearm was scabbing over and left open to air (OTA). Dressing removed from old S/T at lower extremity (LE) and site is OTA. States can use vasoline to remove liquid dressing in 7 days if it has not worn off." R28's Progress Note, dated 10/10/2021 at 4:20 PM, documents "Called to (R28)'s room at this time to find resident lying on her back in front of her recliner with bleeding noted on the floor and on residents head. Unable to assess resident for bleeding head wound resident would not lay still." R28's Care Plan was not revised with progressive interventions to prevent her from falling in the future after this fall occurred. R28's Progress Note, dated 11/09/2021, document at 7:00 PM "R28) observed leaning against recliner with knees on floor and arms/elbows on seat of recliner. (R28) facing recliner. ROM to extremities with no sign/symptoms (s/s) increased difficulty of movement. (R28) assisted into low bed. Observed bruise at left knee, bruise on Rt knee, ecchymotic area on Rt elbow, and skin tear (S/T) at outer side of right knee. S/T site approximated and steri strips applied." R28's Care Plan Intervention, updated on 11/10/21, documents "When resident is self propelling in wheelchair towards her room, offer to assist her into her recline."	S9999		

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S9999	Continued From page 16 R28's Progress Note dated 11/18/2021 at 02:13 AM, documents "(R28) observed on the floor, between foot of bed and bathroom door. Resident was found on her back with head at foot of bed, feet facing the bathroom door. Room was well lit with bed in low position, call light in reach. When asked what happened resident stated she didn't know. Resident was incontinent of stool and had large BM. Resident range of motion (ROM) within desired limits (WDL), extremities equal in length. No injuries are noted at this time. Resident does state that her back hurts, As needed (PRN) Tylenol given for pain. Resident was taken to the bathroom, incontinent care provided and assisted back to bed x2 staff. Resident was unable to bear weight while in bathroom with the assist x 2. Once in bed resident stated that she couldn't breathe, 96% on room air, 97.2, 99, 124/68, 16. 2liters/oxygen (O2) placed for comfort. HOB is elevated. Will continue to monitor. fax sent to MD, will update Power of Attorney (POA) at appropriate time." R28's Care Plan was not revised after the fall on 11/18/21 with progressive interventions to address her need for supervision and prevent future falls. On 1/5/22,V2, Director of Nurses (DON) stated, "She has had a lot of falls. We know when she isn't feeling well or had a UTI this happens more often. New interventions should be put in place with each fall." (B)	S9999		