STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009203	A. BUILDING: _____ B. WING _____	C 10/18/2022

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INTEGRITY HC OF CARBONDALE	120 NORTH TOWER ROAD CARBONDALE, IL 62901

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S 000	Initial Comments Complaint Investigation: 2258102/IL152123	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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. These Requirements were NOT MET as evidenced by: Based on interview and record review, the facility	S9999		

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S9999	Continued From page 2 failed to correctly assess a resident for risk of falls upon transfer/admission and ensure fall prevention interventions were in place for one (R2) of 3 residents reviewed for risk of falls in the sample of 9. This failure resulted in R2 falling, fracturing her right humerus and sustaining right hand injuries including fracture of the 3rd digit, fracture of the distal phalanx of the 4th digit and amputation of the distal tip of the 4th digit. Findings Include: R2's Admission Record documents an admission to the facility on 9/1/22 with a Primary Diagnosis of Covid-19 and that R2 was admitted from a local sister facility. This same document shows R2 was discharged on 9/11/22 at 10:43AM back to the sister facility and length of stay was 10 days. R2's Admission record from the previous/sister facility documents an original admission date of 6/13/22. R2's Fall Risk Assessment dated 6/13/22 from the discharging/sister facility notes R2 had a score of 14. The same document notes if the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. The facility document titled "Fall" from the discharging sister facility dated 9/1/22 at 0243 (2:43am) notes that R2 was attempting to self-transfer to the wheelchair to use the restroom, but her legs got weak, and she fell. This same report documents R2 had no injuries, and notes the following immediate action taken: "VA (visual aid) placed in room to use call light when needing assistance." R2's corresponding Fall Risk Assessment dated 9/1/22 at 0243 (2:43am) from the discharging	S9999		

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S9999	Continued From page 3 sister facility notes that after the fall described above, R2 was scored a 12 on this assessment. This document notes if the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. R2's medical record at the admitting sister facility shows no evidence of a Transfer or Admission progress note on 9/1/22 to document the time of transfer/admission or reason for admission to this facility. R2's Fall Risk Assessment completed after transfer to the admitting sister facility dated 9/1/22 at 11:56am documents a fall risk score of 5.0. The same document notes if the total score is 10 or greater, the resident should be considered at HIGH RISK for falls. The facility policy titled "Fall Management" with review date of 2019 notes the admitting nurse and assigned CNA (Certified Nurse Aide) and/or designee are responsible for initiating safety precautions at the time of admission. Facility staff are responsible for assuring ongoing precautions are put in place and consistently maintained. R2's undated Baseline Care Plan documents an admission date of 9/1/22 to the admitting sister facility and documents the following under the section titled "Safety Risks:" No history of falls and no use of alarms or any other safety devices. Under the section titled "Comments" is written "Here R/T (related to) + Covid (positive Covid), assess resp (respiratory) status." V13 (Registered Nurse/RN) signed as completing this document on 9/1/22. This document makes no mention of R2's fall on 9/1/22 that occurred at the previous facility hours before admission, nor is there documentation of an intervention for a	S9999		

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S9999	Continued From page 4 visual aid to be placed in R2's room to use call light when needing assistance. A Fall note dated 9/6/22 at 0200 (2:00am) documents R2 was found in her room on her back with her legs facing back toward her bed and her right arm was above her head. Blood was noted to be coming from right hand after cleaning area noted right ring fingertip was missing, found tip of finger laying away from her next to door. R2 stated she was getting up to go to the bathroom. R2's Fall investigation documents a date of 9/6/22 completed by V2 (Regional Clinical Director) and states "Call received at approximately 2:20am from charge nurse (name of V12/LPN) informing of a fall that occurred with (R2). (R2) sustained an injury to her right hand ring finger and pain to shoulder and hip. Staff working the Covid unit at the time of fall was (V12) and (V10/CNA)." This document further notes that V12 stated that she and V10 were making bed check rounds together and were across the hall from R2's room. As they were finishing up with care on another resident, V10 heard a noise across the hall and heard R2 yell. V10 went immediately to the room and summons V12. They both had to squeeze through the door as R2 was in front of the door laying on the floor. V12 assessed R2 at this time, R2 was laying on her right side/back with right hand behind her head. V12 noticed blood and when she assessed she noted that injury was to right hand ring finger. V12 noted that the tip of finger was missing and was noted on the floor by the door. R2 also complained of right shoulder pain. V12 noticed that the bed was in high position. V12 also noted that call light was on the bed. V12 stated that right before they went into the room across the hall she glanced into R2's room and she was sleeping	S9999		

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with bed in lowest position. R2 had an electric bed. V12 also stated that they were in the room across the hall providing care for a few minutes. Notifications were made and resident was transferred to the hospital via EMS. V10's interview documents that she and V12 were working together on bedchecks and were across the hall from R2. As they were finishing up the care, she heard a noise from the room across the hall so she went to check on (R2) and squeezed open the door a little and saw (R2) on the floor so she yelled for V12. V12 came immediately and they both squeezed through the door and V12 started assessing (R2). V10 said she also noticed that the bed was in the high position. V10 said that (R2) was then transferred to the hospital by ambulance. V10 stated that she had taken R2 to the BSC (bedside commode) 3 times prior to the fall. She stated that she did well on the transfer to and from the bed and BSC. When I asked V10 if (R2) was alert and oriented prior to fall and she stated "yes she seemed good." (R2) arrived back to the facility at around 6:20am. She has sutures to right hand ringer finger and dx (diagnosis) of fx (fracture) to right shoulder. (R2) has a sling in place. (V2) requested maintenance do a check on the bed for proper functioning and for any sharp edges or areas on the bed. No issues noted with the bed from the maintenance department. Fall interventions have been put into place upon hospital return of Fall Mat, education to resident on bed remote and to keep bed in lowest position, and maintenance check on bed. Intervention put into place to reduce risk of fall. Investigation continued: Review of hospital records and radiology reports: 3 view Right Shoulder: Transverse fx of surgical neck of the proximal right humerus, mildly displace of greater tuberosity. Right hip: No findings, no acute osseous abnormality. Right Hand: amputation of

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distal tip of the 4th digit with fx of 4th distal phalanx. Resident has to follow up with ortho and this report was given to (name of discharging sister facility).

A local hospital emergency Department note dated 9/6/22 documents a wound debrid/explore was done to R2's right ring finger and notes Ronger of distal phalanx performed with undermining and flap closure. The same emergency department note also documents an x-ray of right hip 2 view include pelvis was performed with impression of no acute osseous abnormality, x-ray of right shoulder 2 plus view was performed and impression notes a transverse fracture of the surgical neck of the proximal right humerus. There is a mildly displaced fracture of the greater tuberosity, x-ray of right hand 3 plus view notes impression that a fracture of the tuft distal phalanx of the third digit. There is amputation of the distal tip of the fourth digit with fracture of the distal phalanx of the fourth digit. Emergency Department note also notes a splint application to the right upper arm and comments were discussed with orthopedic surgeon on call for outpatient follow up. Emergency room note also documents R2 will be getting discharged and heading back to the facility soon.

On 10/13/22 at 10:25AM, V12 (RN/Registered Nurse) said that V10 and herself were in the room directly across the hall from R2's room on the COVID unit. V12 said she had been up and down the hall all night and that R2's bed was in the lowest position. V12 said she was walking back to her medication cart when V10 yelled at her. V12 said that R2's door was hard to open and had to squeeze to get in. V12 said that R2's bed was not in its lowest position at that time. V12 said that R2

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had an electric bed. V12 said that R2 was in the floor in front of the door with her head against the wall and her hand behind her head. V12 said she saw blood but it was not a lot so she figured it was not from her head since a head wound bleeds a lot. V12 said she got R2's hand and noticed the tip of R2's ring finger was missing. V12 said the tip of the finger was to the right of R2 and her head was to the left of the door. V12 said they used a blanket to pull R2 away from the door just far enough to get the door open. V12 said that R2 never pushed her call light or yelled for help as they were just across the hall and would have heard her. V12 said that while being a resident at the facility, R2 would have increasing confusion in the evenings. V12 said that R2's daughter told her that R2 had fallen at the previous facility after R2's fall at this facility. V12 said she did not admit any of the residents from the sister facility and was not aware she was a high risk for falls at the other facility.

R2's MDS (Minimum Data Set) dated 9/8/22 documents a BIMS (Brief Interview for Mental Status) score of 09, which indicates moderate cognitive impairment. Section G of the same MDS documents R2 requires extensive assistance with transfers - how resident moves between surfaces including to and from bed, chair, wheelchair, standing position and the support provided is one-person physical assist. The same MDS notes that R2's balance during transitions and walking is not steady, only able to stabilize with staff assistance.

On 10/12/22 at 8:00 am, R2 was interviewed back at the original sister facility. R2 had a sling on her right arm. When questioned about the fall at the other facility, R2 said she "didn't remember what happened" and said "honey, that was a long

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S9999	Continued From page 8 time ago." On 10/13/22 at 10:07am, V13 (RN/Registered Nurse) said that she admitted a lot of the residents to the COVID unit from the sister facility. V13 said she was upset over not getting a call from the sister facility to give report on any of the residents she received. V13 said she completed the fall risk assessment as well as other admission assessments on R2 based on talking to R2 and looking at her medications. V13 said she can't answer if she received a transfer sheet or not. V13 said she was never told that R2 had fallen prior to her arrival, or she would have changed the way she did her fall risk assessment. V13 said it is frustrating when you know nothing about a resident. V13 stated she usually puts a progress note in on residents she admits saying what time they arrived and other pertinent information. V13 said if there is not a progress note in R2's medical record, she guesses she did not have time to do it. On 10/13/22 at 11:30am, V2 (Regional Clinical Director) said that it is her understanding that report was called from the (discharging) sister facility. V2 stated that they do not send care plans; V2 said they send Physician Orders, MARS (Medication Administration Records), TARS (Treatment Administration Records) and the face sheet. V2 said that they transfer COVID positive residents from the (discharging) sister facility due to that facility being small causing them to have to share shower rooms with non-COVID positive residents. On 10/13/22 12:27pm, V14 (Interim DON/Director of Nursing) at the discharging facility stated that when they send a resident to another facility, they send Physicians Orders, TARS (Treatment	S9999		

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Administration Records), MARS (Medication Administration Records), medications and the resident face sheet. V14 said they usually use a transfer sheet when a resident goes to the hospital. V14 said the nurse always calls report also. V14 said she is not sure if fall risk assessments were sent.

On 10/13/22 at 3:35pm, V11 (LPN/Licensed Practical Nurse) said she was the nurse at the (discharging/sister) facility that discharged R2 to come to this (admitting/sister) facility. V11 said she called the facility prior to sending R2 and two other residents that were sent at that time. V11 said that there were three residents that went (transferred) the morning of 9/1/22 and others went later. V11 said she did not get the name of the nurse she called report to. V11 said she informed them that R2 had a fallen at their facility in the early morning on 9/1/22 before she was sent. V11 said she also told them she had no apparent injuries, was positive for COVID, there were no areas on concerns, had chronic pain management with pain meds being scheduled. V11 said that she sent a copy of R2's MAR, physician's orders as well as all of R2's medications. V11 said she did not send a transfer sheet or care plan.

On 10/18/22 at 2:20pm, V10 (CNA) said she came in at 7pm the evening of 9/5/22 and had assisted R2 to the bedside commode 2 times prior to R2 falling. V10 said when she checked on R2 each time, she noticed R2 may be trying to do too much herself, so she helped her to the commode. V10 said R2 transferred well. V10 also said the last time she helped R2 to the bed side commode was about 2 hours prior to her fall and that when V10 returned to R2's room, R2 had put herself back to bed. V10 said she told R2 to not

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S9999	Continued From page 10 do that and to be sure and call for help. (A)	S9999		