STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009823	A. BUILDING: _____ B. WING _____	C 09/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCOLA HEALTH CARE CENTER	422 EAST FOURTH STREET ARCOLA, IL 61910

(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 FRI of 8/27/2022/IL151239	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210c) 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. These Requirements were NOT MET as evidenced by: Based on interview and record review the facility failed to transfer a sleeping resident from her wheelchair to her bed, which resulted in a fall and subsequent injury for one cognitively impaired resident (R1). R1 was sent to the Emergency Room, seen, and treated for a forehead laceration and right and left nasal bone fractures after falling at the facility on 8/27/22. R1 is one of	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 three residents reviewed for falls in the sample of three. Findings include: R1's Physician Order Sheet (POS) dated September 2022 documents R1 is diagnosed with Dementia, Anxiety, Depression, Behavioral Disturbances with Psychosis, Altered Mental Status, and Seizure-like Activity. R1's Minimum Data Set (MDS) dated 8/3/22 documents R1 is severely cognitively impaired. R1's Care Plan dated 8/18/22 documents R1 is at high risk for self injury as evidence by previous falls with injuries, declining cognitive status, and resistance to wait for staff assistance with transfers. R1's Final Report: Fall with Injury dated 9/2/22 documents R1 fell on 8/27/22 at 3:00 PM. R1 was sitting in her wheelchair at the nurses' station. Nurses were giving report and conducting narcotic medication count when they heard R1's chair alarm sound and looked over to see her lying on the floor with blood coming from the right side of her forehead and bridge of her nose. Prior to the fall R1 was observed sitting in her wheelchair sleeping in an upright position with her head tilted back. R1 was sent to the Emergency Room. R1 was diagnosed with a forehead laceration and nasal bone fractures. R1's Maxillofacial Computed Tomography (CT) Scan Report dated 8/27/22 documents R1 fell at the facility and sustained right and left nasal bone fractures and rightward deviation of the nose. On 9/21/22 at 2:00 PM V3 Licensed Practical	S9999		

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S9999	Continued From page 2 Nurse stated she had just given report and started counting the narcotic medications. R1 was sleeping in her wheelchair by the nurses station. R1 is confused, a high fall risk, and never asks for help with transfers. R1 had her head tilted back while sitting upright in her wheelchair and she was "zonked". V3 stated she did not ask staff to put her in her bed when she noticed her sleeping. A few minutes later, R1's chair alarm went off and V3 looked over and saw R1 lying face down on the floor, in front of her wheelchair. R1 had tipped forward while sleeping and fell onto her face. R1 had hit her nose and head on the floor. She had a laceration to her forehead. Staff sent her to the Emergency Room and R1 had nasal bone fractures. On 9/22/22 at 10:05 AM V8 Certified Nurses Assistant (CNA) stated R1's sleep pattern is very messed up. She often won't sleep at night and will fall asleep during the day. She will fall asleep in her wheelchair and often leans to one side. If she falls asleep in her chair staff are supposed to lay her in her bed. On 9/22/22 at 10:50 AM V2 Director of Nurses confirmed R1 is a high fall risk. She has had previous falls. She is confused. She does not know her limits. She does not call for help. She has a very erratic sleep pattern and will often stay awake all night and fall asleep during the day. She will fall asleep in her chair and if she does, staff are to put her in her bed. If she falls asleep in her chair she often leans to one side or another and could easily fall out. V2 DON confirmed when R1 fell asleep in her wheelchair, staff should have laid her down in her bed. On 9/22/22 at 11:48 AM V9 Medical Director stated R1 is a very high fall risk while she is	S9999		

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S9999	Continued From page 3 awake, asleep, in bed, and in wheelchair. R1 does not know her own limits and she does not call for help. V9 stated if R1 fell asleep in her wheelchair, then staff should have laid her down in her bed. V9 confirmed it wouldn't be safe to sleep sitting upright in a regular wheelchair and if R1 had been laid down, she would not have fallen out of the chair while sleeping. The Fall Prevention policy dated 11/10/18 documents the policy serves to provide resident safety and minimize injuries related to falls. All staff must observe residents for safety. (B)	S9999		