STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009310	A. BUILDING: _____ B. WING _____	C 04/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE MANOR	920 N SEMINARY AVE WOODSTOCK, IL 60098

(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 Original complaint investigation survey. 2212037/ IL# 144635	S 000		
S9999	Final Observations Original complaint investigation survey. 2212037/ IL# 144635 Statement of Licensure Violations: 330.780a) 330.1720c)3) Section 330.780 Accidents and Incidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 330.1720 Content of Medical Records c)In addition to the information that is specified above, each resident's medical record shall contain the following: 3)An ongoing record of notations describing significant observations or developments regarding each resident's condition and response to treatments and programs. This requirement was not met as evidenced by: Based on interview and record review the facility failed to document a resident's fall for 1 of 3	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 residents (R1) reviewed for falls in the sample of 3. The findings include: R1's profile face sheet documents R1 was admitted to the facility on 7/26/21. On 8/12/21, R1 was transferred to the sheltered care area. The facility admission assessment of 7/30/21 documents R1 has severe cognitive impairment and requires extensive assistance of one person for transferring to and from bed or chair. The facility's final incident report of 9/14/21 shows on 8/31/21 at 9:50 PM, R1 was found sitting on the floor next to R1 bed. The investigation notes show R1 was sitting up with both legs stretched out in front of R1. An initial assessment was performed by V7 RN (Registered Nurse), and R1 was transferred back to bed. At 4:00 AM on 9/1/21, R1 was found to have a shortening and external rotation of her right leg. A review of R1's nursing progress notes for 8/31/21 does not show documentation of the fall, any physical assessment or notifications to the family or physician. On 4/9/22 at 12:15 PM, V2 DON (Director of Nursing) said she(V2) reviewed R1's record and did not find an incident report relating to R1's fall on 8/31/21. V2 said V7 (RN) should have completed an incident report. The report would include the date and time of the incident, location of the event, vital signs, and a description of the occurrence. V2 said upon reviewed of the record, no vital signs were recorded, and no assessment was documented for R1's fall. On 4/9/22 at 9:15 AM, V5 RN said when a	S9999		

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S9999	Continued From page 2	S9999		

resident has a fall, an incident report is completed and document notifications of the physician and the family. The documentation of the incident would include an assessment of the resident and vital signs. The assessment would include a neurological assessment, pain, range of motion and a head to toe skin check for any bruising or skin tears. V5 said all of the information should be in the progress notes.

On 4/9/22 at 1:50 PM, V6 RN stated V6 does remember R1 to be at risk for falls and would try and stand up by herself and that R1 was difficult to redirect. V6 said R1 denied pain when she(V6) initially began her shift on 8/31/21 at 11:00 PM. V6 said as the night went on something did not seem right with R1, and V6 did a complete check on her, and found R1 leg to be externally rotated. V6 said she did not recall the time, but it was closer to morning. V6 said the fall details and assessment of R1 should have been in the progress notes.

The facility's December 2009 policy for fall prevention program documents C. Resident-Specific Assessment and Care Planning: 7. Comprehensive investigation is initiated immediately following any occurrence to determine cause/probable cause; care plan approaches are revised/added as necessary. Initiate 72 hour charting/ assessment and monitoring after each incident to observe any change in condition.

(C)