| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6005946 | A. BUILDING: _____ B. WING _____ | C 01/26/2022 |

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| MCLEAN COUNTY NURSING HOME | 901 NORTH MAIN NORMAL, IL 61761 |

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| S 000 | Initial Comments<br><br>Investigation of Facility Reported Incident IL142799 of 1/5/22 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.1210b)5)<br>300.1210c)<br>300.1210d)6)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br>5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.<br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>seven-day-a-week basis:<br>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.<br><br>These requirments are not met as evidenced by:<br><br>Based on observation, interview, and record review the facility failed to implement fall prevention interventions as outlined in residents' plans of care. This failure affects two residents (R1 and R3) of three reviewed for fall prevention in the sample of three. This failure resulted in R1 experiencing a fall with pubic bone fractures and R3 experiencing a fall with a laceration requiring sutures in the forehead.<br><br>Findings include:<br><br>1.) R1's Face Sheet dated 1/25/22 documents R1 was admitted to the facility 12/15/21 with medical diagnoses including Encephalopathy, Convulsions/ Seizures, Dementia with Behavior Disturbance, Repeated Falls, Glaucoma, and Urge Incontinence.<br><br>R1's Fall Risk Assessment dated 12/15/21 documents R1 received a score of 15 points, rating R1 as a high risk for falls.<br><br>R1's Care Plan initiated 12/15/21 documents a fall prevention intervention, which includes for staff to "ensure non-slip socks are on resident."<br><br>R1's Nurses Notes dated 12/26/21 document a fall experienced by R1 at 10:42 am, incurring a hematoma to the right side of R1's head. The | S9999 | | |

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| S9999 | Continued From page 2<br>facility's recommendation as documented on R1's Event Report for this fall was to repeat the same intervention "ensure non-slip socks are on resident." R1's Care Plan did not document any new fall prevention intervention in response to this fall on 12/26/21.<br><br>R1's Nurses Notes and Incident Report dated 1/5/22 document R1 experienced a fall on 1/5/22 at 3:21 am. According to a documented interview with V5 Certified Nursing Assistant, R1 was wearing regular socks when this fall occurred. R1's Computed Tomography scan report dated 1/6/22 documents R1 experienced fractures of the right inferior pubic ramus (lower pubic bone), right acetabulum (hip bone socket), and right pubic symphysis (joint between the two upper pubic bones).<br><br>On 1/25/22 at 10:50 am, V8, Licensed Practical Nurse, stated, "(R1) usually wore shoes when out of bed. (R1) maybe could put his own shoes on, but someone would need to tell (R1) to do it. (R1) wasn't wearing (non-slip) socks when he fell at 3 in the morning because second shift put him in bed without the (non-slip) socks."<br><br>On 1/25/22 at 11:40 am, V2, Director of Nursing, confirmed R1 was not wearing non-slip socks at the time of the fall experienced on 1/5/21 stating R1 had a preference to not wear them because R1 did not like the feeling of the non-slip socks inside of his shoes.<br><br>On 1/25/22 at 3:15 pm, V15, Registered Nurse/ Unit Director, stated, "(R1) probably could put on his own shoes if they were the slip-on type, but (R1) wasn't cognitively aware of safety needs and would need someone to tell him to put them on." | S9999 | | |

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| S9999 | Continued From page 3<br>On 1/26/22 at 2:47 pm, V1, Administrator, confirmed there was not an intervention placed on R1's Care Plan for the fall on 12/26/21.<br><br>R1's Occupational Therapy Notes dated 12/30/21 document R1 required "partial to moderate assistance to put on or take off footwear." Partial to moderate assistance is defined in these notes as "Helper does less than half the effort, lifts/ holds/ supports trunk or limbs." These notes document an anticipated goal for R1 to achieve a level of function requiring only supervision or touch assistance to put on or take off footwear. R1's Occupational Therapy Discharge Note documents R1 was discharged from Occupational Therapy 12/30/21 with "Goal Not Met."<br><br>2.) R3's Face Sheet dated 1/25/22 documents R3 was admitted to the facility 1/5/22 with medical diagnoses including Cognitive Functional Impairments, Repeated Falls, and Urinary Tract Infection.<br><br>R3's Fall Risk Assessment dated 1/5/22 documents R3 received a score of 15 points, rating R3 as a high risk for falls.<br><br>R3's Care Plan initiated 1/5/22 documents fall prevention interventions including "observe frequently and place in supervised area when out of bed." This Care Plan documents another fall prevention intervention for staff to "keep personal items within reach."<br><br>R3's Nursing Notes and Event Report dated 1/17/22 document R3 experienced a fall on 1/17/22 while (by herself) in her own room eating lunch. The 1/17/22 at 5:25 pm nurses note for R3 documents, "Resident was yelling out, 'help, I | S9999 | | |

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| S9999 | Continued From page 4<br>fell.' This writer and CNA went to residents' room and observed her lying on the floor on her right side with a puddle of blood near her head." This Nursing Note documents R3 experienced a laceration over the right eyebrow requiring a visit to the hospital emergency room and sutures.<br><br>R3's Emergency Report dated 1/17/21 documents R3 received 5 sutures for the repair of a 3 centimeter forehead laceration.<br><br>R3's Nurses Notes and Event Report dated 1/23/22 document R3 experienced a fall on 1/23/22 in front of her recliner while in her own room. The facility's intervention in response to this fall was to repeat the same intervention "have resident in supervised area as able."<br><br>On 1/25/22 and 1/26/22, R3 was seated in her own room at all observations including 1/25/22 at 10:50 am and 3:30 pm, and 1/26/22 at 10:40 am. On 1/26/22 at 10:40 am, R3's wheelchair and walker were approximately 8 feet and 6 feet away from R3's chair, respectively.<br><br>On 1/25/22 at 10:50 am, V8, Licensed Practical Nurse, stated, "(R3) is able to use the call light, otherwise we would have her out to be supervised by the nurse's station with all the other frequent fallers."<br><br>On 1/25/22 at 3:30 pm, R3 was seated in her own room calling out repeatedly, "Can you help, me? Can you bring me some food in Jesus' name?" R3 did not respond to suggestions to utilize the nurse call system in order to gain staff attention, simply kept repeating the statements, "Can you help me? Can you bring me some food in Jesus' name?" | S9999 | | |

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