STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007702	A. BUILDING: _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH COUNTY CARE CENTER	312 WEST BELMONT SPARTA, IL 62286

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 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 resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 be knowledgeable about his or her residents' respective resident care plan. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement fall interventions for 1 of 4 residents (R33) reviewed for accidents in the sample of 25. This failure resulted in R33 suffering a fall resulting in a subdural hematoma requiring hospitalization for monitoring and treatment. Findings Include: R33's "Admission Record" documents R33's original admission date to facility as 1/3/22. R33's Minimum Data Set (MDS) dated 1/10/22 documents a BIMS score of 09, indicating cognitive impairment. This same MDS documents in Section G0110 that R33 requires limited assistance from 1-person physical assist for transfers, walking in room, and walking in corridor. R33's "Morse Fall Scale" dated 1/3/22 documents a score of 75, indicating R33 is at high risk for falls. R33's Plan of Care documents a focus area that states, "The resident is high risk for falls r/t	S9999		

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S9999	Continued From page 2 (related to) Confusion, Gait/balance problems, unaware of safety needs." An intervention listed for this focus area documents a date initiated as 1/10/22 which states, "The resident uses chair/bed electronic alarm. Ensure the device is in place as needed." Facility Final Report incident dated 1/24/22 documents a fall with major injury for R33. The report states, "Upon further investigation of fall from 1/17/22, per nurse's notes and staff interviews, resident had been sitting at the table outside of the nurse's station where (R33) ate (R33's) evening meal. The nurse was with R33 and had left the area to take medications to another resident. Nurse states she was gone for no longer than 5 minutes. Upon her return, nurse found Resident laying on R33's back on the opposite side of the table. Resident had (R33's) walker with (R33), no objects noted on the floor which is carpeted. Resident was admitted 1/3/22. Diagnosis of dementia with a BIMS (Brief Interview for Mental Status) score of 9. Requires SBA (stand by assistance) - A (assist)x1 for locomotion. Resident is forgetful and attempts to ambulate without assistance. Admitted for rehab after frequently falling at home, last fall resulting in left femoral neck fracture requiring a pinning and acute subdural hematoma according to CT (computed tomography) scans from 12/28/21. CT scans from 1/17/22 show acute on subacute subdural hematoma. Resident continues to be admitted to (Name) out of town hospital at this time with an expected return to our facility tomorrow 1/25/22." On 2/17/22 at 9:59 am, V2 (Director of Nursing) states that she completed the fall investigation for R33 regarding the 1/17/22 fall. V2 states it was determined R33's chair alarm had been left on a	S9999		

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S9999	Continued From page 3	S9999		

chair in R33's room, while R33 fell from a chair located in the lounge area outside of the nurses' station. V2 states R33 had a history of falls and staff were educated on ensuring R33's chair alarm was moved to whatever chair R33 was utilizing. V2 confirms R33's Plan of Care indicated R33 was to have a chair alarm in place. V2 states R33 received hospital evaluation and treatment for a subdural hematoma as a result of the fall. V2 states that R33 had a smaller subdural hematoma from a fall prior to R33's admission to the facility, but after the fall on 1/17/22, reports show it had now grown in size.

On 2/17/22 at 10:25 am, V4 (Certified Nurse Assistant) states that she was working with R33 on 1/17/22 when she fell. V4 states that she did not witness R33's fall but arrived later after the fall had occurred and V5 (Licensed Practical Nurse) was tending to R33. V4 states that R33 utilized a bed and chair alarm. V4 states that R33 did not have R33's chair alarm in place at the time R33 fell. V4 states that R33 had been with visitors who had brought R33 to the lounge area at the end of the visit. V4 states the chair alarm was not put back in place after the visitors left. V4 confirms education was provided on ensuring R33's alarm is present and working wherever R33 is sitting.

On 2/17/22 at 1:58 am, V5 (Licensed Practical Nurse) states that she was working the night R33 fell. V5 states that R33's baseline status is confused. V5 states that R33 utilizes a chair alarm and confirms it was not in place at the time of the fall. V5 states that R33 was sent to the local emergency room for evaluation and treatment.

R33's Clinical Record documents a nursing note made on 1/17/22 with an effective time of 5:45

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S9999	Continued From page 4 pm which documents R33's blood pressure and pulse were elevated post fall. The same note documents a 3.0 cc hematoma was present to the back, upper, left portion of R33's head. R33's pupils were differing in size, with the right measuring 4 mm (millimeter) and left measuring 2 mm. V18 (physician) was contacted with orders to send R33 to the local hospital for evaluation a treatment. R33's local hospital Emergency Department "Clinical Report" documents R33 arrived by ambulance and was seen on 1/17/22 at 7:08 pm. Review of the Radiology Report located in this same document dated 1/17/22 documents a CT Scan of the Brain was complete without contract. The "Impression" listed on this report documents, "1. Acute on subacute subdural hematoma in the left cerebral fossa measuring up to 17 mm with associated mass effect on the left hemisphere and approximately 6 mm of left-to-right midline shift. 2. There appears to be a small volume of left subarachnoid hemorrhage...." This report documents under "Progress and Procedures" that the case has been discussed with trauma service and R33 will be transferred to an out-of-town hospital for a "Medium sized, chronic, traumatic left subdural hematoma." R33's "Neurosurgery Consult Note" from the out-of-town hospital dated 1/17/22 made by V6 (Physician) documents an "Assessment" stating, "80 year old female with prior fall and small SDH (subdural hematoma) presents s/p (status post) fall tonight with increasing size to SDH to 17 mm with 5 mm midline shift. Neurologically intact but confused. Concern for acute deterioration, so recommend ICU (Intensive Care Unit) care. Will discuss possible surgical intervention with patient and family."	S9999		

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S9999	Continued From page 5 R33's out of town hospital "Summary of Care" documents R33 was admitted to the hospital from 1/17/22 - 1/25/22 with a primary diagnosis of "Subdural hematoma." This report documents repeated CT scans of the Brain were complete along with neurological referral and treatment of the subdural bleed. Imaging Results for a CT of head without contract complete on 1/20/22 documents in Findings that R33 "Is now status post left frontal approach subdural drain placement. There is a mild interval decrease in the size of the left cerebral convexity subdural collection. The maximum depth of this residual collection is approximately 0.8 cm (previously 1.2 cm). The collection is predominately hypodense with minimal hyperdense blood products. The mass effect on the left cerebral hemisphere and ventricles is significantly decreased. There is residual bowing of the septum pellucidum with near complete resolution of the midline shift." R33 was discharge back to the facility on 1/25/22 with orders to follow up with R33's Primary Care Provider in two weeks. R33's "Subdural Drain Procedure Note" documents on 1/18/22, R33 had a subdural drain placed. The note documents a 2 (centimeter) incision was made. Subcutaneous tissue and the galea were dissected until the skull was identified. A handheld twist drill was used to create a burr hole. The burr hole was undermined with a straight bone curet. The dura was incised in a cruciate fashion with a #11 scalpel blade. A trauma catheter was inserted and directed frontally and tunneled away from the incision site. Dark brown crank case fluid consisted with a chronic subdural hematoma was visualized upon dural incision and within the collection system. The drain was secured to the skin with nylon	S9999		

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S9999	Continued From page 6 suture. The catheter was serilly connected to the distal collection system with confirmation of spontaneous flow of fluid through to the collection system. After appropriate hemostasis was obtained, the wound was closed with running nylon suture." On 2/15/22 at 10:36 AM, R33 was observed residing in the facility, sitting in R33's wheelchair, with a functioning chair alarm in place. R33 was alert to person only. The facility's undated policy titled, "Fall Policy" states the mission statement is, "to identify residents at risk for falls and provide guidelines for prevention and treatment post fall." "A"	S9999		