STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004188	A. BUILDING: _____ B. WING _____	C 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES REHAB & HEALTH CARE	310 EADS AVENUE PARIS, IL 61944

(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 Investigation of Facility Reported Incident of 5/18/22/IL147448	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b)5) 300.1210d)3) 300.1210d)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	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. 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. These requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to implement interventions for known behaviors of a resident (R4) with Dementia. This failure resulted in R1 falling from the bed and sustaining a right hip fracture. R1 and R4 are two of four residents reviewed for falls in the sample list of 4.	S9999		

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S9999	Continued From page 2 Findings include: The facility's Incident Report Form - IDPH (Illinois Department of Public Health) Notification dated 5/18/22 documents R1 rolled out of bed in the early morning on 5/18/22. R1 later complained of pain and was hospitalized on 5/18/22 at 12:30 PM. The Final Incident Report-IDPH Notification for R1's 5/18/22 fall investigation documents: R1 was attempting bed mobility and R1's right side is flaccid due to CVA (Cerebral Vascular Accident.) R1 was unable to stop rolling and landed on R1's right side on the floor. The next morning R1 complained of right hip pain. R1 was transported to the hospital and R1 had a right hip fracture. R1's Minimum Data Set (MDS) dated 4/6/22 documents R1 has functional limitation to one upper and lower extremity and is dependent on two staff for transfers. R1's Care Plan documents R1 has right sided hemiplegia related to CVA, and R1 uses 1/4 bed rails for bed mobility. R1's Fall Report dated 5/18/22 documents: At 2:30 AM R1 was heard yelling and was found lying on R1's right side on the floor. R1 was yelling that R1's roommate (R4) "was trying to get over here to me (R1) and I (R1) fell OOB (out of bed.)" R1 had muscle spasms noted to R1's right leg. R1's Nursing Note dated 5/18/22 at 9:40 AM documents R1 complained of pain to the right leg and was not able to bend or move R1's leg as prior to R1's fall. R1's hip and pelvis x-ray report dated 5/18/22 at 12:56 PM documents the reason for the x-ray as "Right hip pain from a falling injury", and the x-ray showed "an intertrochanteric fracture of the right hip." R1's Hospital Summary dated 5/21/22 documents: R1's hospital discharge diagnosis is	S9999		

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S9999	Continued From page 3	S9999		

a closed fracture of the hip. R1 was admitted to the hospital on 5/18/22 "after a fall from bed at local SNF (skilled nursing facility) which resulted in fracture to right hip/surgical repair/nailing."

The Resident Notification of Room/Roommate Change forms document the following: R1 and R4 began sharing a room on 3/11/22. R4 was transferred to another room on 5/18/22.

R4's MDS dated 3/7/22 documents R4 has severe cognitive impairment. R4 transfers and walks with setup and supervision. R4's Nursing Notes document: On 4/3/22 at 3:45 PM "While roommate (R1) was in shower, resident (R4) (went) over to roommate's side and ate (R1's) snacks and drank (R1's) coke." On 4/10/22 at 5:30 PM R4 was entering other resident rooms and eating their snacks.

R4's Care Plan documents R4 has Dementia, is confused, and often wanders. R4's Care Plan and April and May 2022 Behavior Tracking does not address R4's behaviors of going through other resident's belongings and taking food from other residents.

On 6/8/22 at 9:47 AM R1 was lying in bed. R1 had difficulty communicating and was only able to respond yes/no to questions. R1 answered yes to having a recent fall and going to the hospital as a result of the fall. R1 was asked if R1 had any injuries from the fall. R1 said yes and pointed to R1's right hip.

On 6/8/22 at 11:14 AM V8 Certified Nursing Assistant (CNA) stated one day while R1 was out of R1's room for a shower, R4 ate R1's candy. On 6/8/22 at 11:19 AM V8 entered R1's room (which R4 no longer resides in), and R4 was lying in the

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S9999	Continued From page 4 bed. On 6/8/22 at 11:53 AM V6 CNA stated: About an hour before R1's fall, V6 heard R1 yelling. V6 went to R1's room, and R4 was going through R1's belongings. V6 assisted R4 back to R4's bed. R4 had previously tried to take R1's candy, and this has happened occasionally over the last month. R4 and R1 "just don't get along." At the time of R1's fall, V6 heard R1 yelling. R1 was found lying on R1's right side on the floor between R1's and R4's beds. R4 was trying to help R1. R1 seemed upset and was pointing at R4. R1 can't talk much, so V6 asked R1 if R4 had tried to get into R1's belongings again. R1 said yes. R1 complained of pain and pointed to R1's right leg. On 6/8/22 at 1:00 PM R1's fall investigation was reviewed with V2 Director of Nursing. V2 stated nothing had been reported to V2 that R1 had been upset with R4 previously. V2 confirmed V6's written statement documents at 1:00 AM V5 CNA and V6 had heard R1 yelling out, and R4 was on R1's side of the room. V2 confirmed V4 RN's written statement documents at the time of R1's fall, R1 was attempting to get R4 out of R1's side of the room, and R1 fell out of bed. On 6/8/22 at 1:56 PM V7 CNA stated: R4 wanders into other resident rooms and goes through other resident's belongings. This is not a new behavior for R4. R4 has taken food from other residents during meals in the dining room. R4 doesn't distinguish between what is R4's and what doesn't belong to R4. On 6/8/22 at 2:02 PM V9 Social Services Director stated V9 was not aware that R4 had taken R1's candy or had gone through other resident's	S9999		

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S9999	Continued From page 5 belongings. On 6/8/22 at 3:06 PM V6 Registered Nurse stated R4 has dementia and doesn't mean anything by it, but R4 rummages through other resident's belongings and has taken food from other residents before. R4 does that all the time, it is a behavior that R4 has. We try to redirect R4. V6 stated at the time of R1's fall, R1 was found on the floor of R1's room on R1's right side. R1 was yelling "get him (R4), get him" and R1 was pointing to R4. R4 had been on R1's side of the room prior to the fall. V6 was asked what was the cause of R1's fall. V6 replied "I assume that (R1) was upset with (R1's) roommate (R4) being on (R1's) side of the room and was trying to get (R1's) roommate (R4) from R1's side of the room." On 6/8/22 at 3:59 PM V2 Director of Nursing stated the facility does not have a policy on dementia or behaviors. V2 stated staff are to report behaviors to V2, and a care plan for the behavior and interventions is developed. V2 stated V2 wasn't sure that R4 taking food from others would be considered a behavior, since R4 has dementia. V2 stated R4 taking food from others and going through other resident's belongings and interventions were not added to R4's behavior tracking until June 2022. (A)	S9999		