STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007389	A. BUILDING: _____ B. WING _____	C 10/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIATT COUNTY NURSING HOME	1111 N STATE ST MONTICELLO, IL 61856

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S 000	Initial Comments Investigation of Facility Reported Incident of 9/23/22/IL152028	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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. Restorative measures shall include, at a minimum, the following procedures: 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. These Regulations were not met as evidenced by: Based on interview and record review the facility failed to implement an intervention from a previous fall which resulted in a recent fall and subsequent injury for one cognitively impaired resident (R1). R1 was sent to the Emergency Room and diagnosed with a fracture of the greater trochanter of the right femur (Hip) following a fall at the facility on 9/23/22. R1 is one of three residents reviewed for falls in the sample of three. Findings include: R1's Physician Order Sheet dated October 2022 documents R1 was diagnosed with Anxiety Disorder, Chronic Fatigue, Unsteadiness on Feet, Alzheimer's Disease, Muscle Weakness, and Indwelling Urethral Catheter. The same POS documents an order to check the function and placement of R1's chair alarm.	S9999		

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S9999	Continued From page 2 R1's Morse Fall Scale dated 8/2/22 documents R1 was at high risk for falls related to a history of falls, use of an ambulatory aide, impaired gait, impaired cognition, and often overestimates or forgets limits. R1's Care Plan dated 8/6/22 documents R1 was high risk for self injury and falls and was to have a bed and chair alarm in place in order to help prevent further falls. R1's Minimum Data Set dated 8/9/22 documents R1 was severely cognitively impaired, used a walker and wheelchair and required extensive assistance of one staff person for transfers. R1's Incident Report dated 9/23/22 documents at approximately 8:00 PM, R1 was in the hallway when she stood up on her own and fell to the floor in front of her wheelchair. R1 stated "I'm trying to get out of here". R1 was on her back and no injury was noted at the time of the fall. R1 was able to transfer back to her wheelchair with staff assistance and denied pain. R1 went to sleep but by the next morning had developed pain/weakness in her right hip. R1 was transferred to the Emergency Room and diagnosed with a fracture of the greater trochanter of the right femur. At the time of the fall, R1 was only orientated to person, R1 was confused, was attempting to ambulate without assistance, had a recent Urinary Tract Infection and had increased confusion and behaviors noted multiple times earlier that same day and earlier that same shift. R1 also had a urinary catheter in place. R1's prior fall intervention of a chair alarm was not in place at the time of her fall. R1's Diagnostic Imaging Report of the Right Hip	S9999		

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S9999	Continued From page 3 dated 9/24/22 documents R1 sustained a mildly comminuted non-displaced fracture of the greater trochanter of the right femur. On 10/17/22 at 4:08 PM V6 Certified Nurse Assistant stated on 9/23/22 she came out of resident's room and saw R1 standing in front of her wheelchair. V6 stated R1 was unsteady and fell to the ground. V6 stated R1 had been more confused and anxious than normal that shift and earlier that evening R1 was climbing out of bed and constantly trying to stand on her own. V6 stated the staff decided to put R1 in her wheelchair and in the hallway so they could attempt to supervise her more closely. V6 stated when R1 fell, there was no other staff in the hallway except her and she had just exited another resident's room. V6 stated she was not aware R1 had a chair alarm that needed to be in her wheelchair when she was in it. V6 stated if she had known this, she would have put the chair alarm in her wheelchair. V6 stated if R1 had the chair alarm on her wheelchair at the time of the fall, it might have alerted her (V6) sooner that R1 was attempting to stand and she could have gotten to R1 more quickly and potentially prevented the fall and subsequent injury. On 10/17/22 at 3:30 PM V4 Licensed Practical Nurse stated she was R1's nurse at the time of the 9/23/22 fall. V4 stated R1 was a high fall risk and was not safe in her room alone due to her increased confusion, anxiousness, and impulsive behavior. V4 stated R1 had poor safety awareness and required supervision. R1 also had a urinary catheter bag at the time of the fall. V4 confirmed R1 was supposed to have a chair alarm in place at the time of the fall however staff had not moved it from R1's recliner to R1's wheelchair when they placed her in the	S9999		

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wheelchair. V4 confirmed if R1 had the chair alarm in place at the time of the fall, it could have alerted staff to her standing up and staff could have possibly gotten to her sooner and prevented the fall and subsequent injury.

On 10/19/22 at 1:30 PM V2 Director of Nurses confirmed R1 was a high fall risk. R1 was confused, had poor safety awareness, required assistance for safe transfers, and was impulsive. V2 confirmed at the time of the fall R1 was supposed to have a chair alarm in place and did not. V2 confirmed staff should have moved R1's chair alarm from her recliner to her wheelchair when she was in her wheelchair. V2 confirmed if the chair alarm would have been in place like it should have, staff could have been made aware of R1 attempting to stand and might have gotten to her sooner in order to prevent the fall and subsequent injury.

On 10/19/22 at 2:05 PM V11 Nurse Practitioner confirmed R1 was a high fall risk with previous falls and all fall interventions should be in place at all times. V11 confirmed staff should have placed R1's chair alarm on her wheelchair when she was transferred into it. V11 confirmed if R1 had the chair alarm in place it could have alerted staff to the unassisted transfer sooner and could have prevented the fall with subsequent injury.

The Managing Falls and Fall Risk Policy dated December 2021 documents the facility will identify interventions related to the resident's specific fall risks in order to prevent the resident from falling and to try to minimize complications from falling. Resident's requiring alarm devices are to be closely supervised during tasks to reduce opportunities for attempting independent mobility.

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S9999	Continued From page 5 (A)	S9999		