STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007868	A. BUILDING: _____ B. WING _____	C 12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT SOUTH HOLLAND, THE	16300 WAUSAU STREET SOUTH HOLLAND, IL 60473

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S 000	Initial Comments Complaint Investigation 2299699/IL154096	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 300.1220 b)3) 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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. c) Each direct care-giving staff shall review and 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to ensure one resident (R1),who is a fall	S9999		

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S9999	Continued From page 2	S9999		

risk and known to be compulsive, was supervised appropriately while sitting at the side of the bed to prevent R1 from falling. This failure resulted in R1 falling onto her wheelchair, being sent to the hospital, and sustaining two skin tears to her arms, and a face injury requiring suturing.

Findings include:

Review of R1's face sheet documents a 99 year old female with diagnoses including: Dementia, Cerebral Atherosclerosis, Major depressive Disorder, Anemia, Anxiety, Lack of coordination, history of falling, Cognitive communication deficit, Weakness, Metabolic encephalopathy, Schizoaffective disorder and Essential hypertension.

R1's MDS (Minimum Data Set) section G, dated 10/13/2022, documents R1 requires one person physical assist with Activities of Daily Living (ADL), and documents R1 is not steady, and only able to stabilize with staff assistance at all times during moving from a seated to standing position, moving on and off the toilet, and surface-to-surface transfer (transfer between bed and chair or wheelchair).

R1's Post Fall evaluation, dated 8/28/2022, documents the following: R1 with a fall risk score of 5. Total score of 5 or above is High Risk.

R1's fall risk evaluation, dated 6/6/2022, documents R1's Fall Risk Score as 16.

R1's fall risk evaluation, dated 10/6/2022, document's R1's fall risk score as 16.

R1's ADL care plan documents the following: Bed Mobility: Physical Assist extensive assist X1.

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S9999	Continued From page 3 Dated 7/11/2019 Dressing: (extensive assist). Dated 7/11/2019 Toileting: Resident requires physical assistance with clothing and wiping. Dated 7/11/2019 Transfers: Resident requires physical assistance (extensive assist X1). Dated 7/4/2019 Review of R1's fall risk care plan is absent of a new intervention after the 11/23/2022 fall and before the 12/5/2022 fall. Review of R1's fall incident reports document the following: *6/28/2022 - Conclusion: R1 tried to self-transfer and due to leg weakness she fell. Another dated the same day states: R1 slip to the floor trying to self-transfer. *10/6/2022- resident found on the floor by CNA with right side of face above eyelid swelling and skin loss noted with scant amount of bleeding. Conclusion: resident slid to the floor while trying to self-transfer from old wheelchair to new one. *11/23/2022 - Resident observed standing up from wheel chair attempting to transfer and fell on the floor. Conclusion IDT met on 12/1/22 about recent fall without injury. Resident has history of Dementia, Cognitive communication Deficit and Weakness. Resident has history of multiple falls due to patient misconception of abilities to self-transfer, self -toilet, and etc. without assistance from staff. Multiple attempts to educate and redirect resident unsuccessful. Resident receiving hospice services. Medical doctor and family aware of no new orders. New interventions for resident to use call light prior to attempts to self-transfer and encourage seated in dining room for socialization. *12/5/2022- CNA present at bedside, R1 slipped off side of the bed, striking head on wheel chair near bedside, causing laceration to left eye.	S9999		

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S9999	Continued From page 4	S9999		

Conclusion: IDT met 12/5/22 regarding recent fall. Resident was receiving care from the CNA, seated on side of the bed and slid off the side of the bed striking head on the wheelchair. Resident is impulsive with diagnosis of Dementia, Anxiety and Cognitive Communication Deficit with history of falls. Upon statement and interviews, resident most likely fell due to awakening from a dream with disorientation of body placement while in bed.

R1's Post fall report, dated 12/5/2022, documents a 2 new wounds one to the right elbow and one to the left hand.

R1's skin and wound evaluation, dated 12/5/12, documents 2 skin tears: Right inner forearm measuring 5.0 cm length X 1.4 cm width and the left inner forearm skin tear measuring 2.9 cm Length x 1.9 cm width.

Hospital records, dated 12/5/2022, documents the following: R1 presented to the emergency room after a fall with laceration to her face that was cleaned and repaired with 1 suture. Per EMS, the facility staff noted that R1 was being transferred from the bed to the wheelchair when she fell and hit her head on the wheelchair.

The facility's incident report documents the following: On 12/5/22 at approximately 5:30 AM, R1 fell off the bed, striking the left side of her face on the wheelchair, sustaining a laceration to the left eyebrow. Resident was sent to (local hospital) and sustained a laceration to left eyebrow with 2 sutures.

On 12/23/2022 at 1:21 PM, V15 (CNA) stated she went into R1's room to get her up for the morning at about 5:00 AM to go to the T.V. room. V15

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S9999	Continued From page 5 stated she sat R1 on the side of the bed like normal, and she turned around to grab R1's shirt off the bed-side table, which was on the left of V15, and when she looked back at R1, her head was on the side of the wheelchair on the right wheel (if you are sitting in the chair). V15 stated she did not see the resident fall onto the wheelchair. V15 stated R1 does not walk, and needs help with transfers and all of her ADLS. V15 stated normally if the resident is tired, she would keep an eye on her to keep her from falling. V15 stated she does not know how R1 got skin tears to her bilateral arms. V15 stated she noticed the skin tear after they had got R1 into bed and told the nurse, V18 (Licensed Practical Nurse/LPN), about the wounds. V15 stated, V18 (LPN) and another CNA helped her get R1 back into the bed. R1's nurse's note by V18 (LPN), dated 12/5/2022 at 5:30 AM, documents the following: "at 5:30 AM the CNA informed the nurse that the patient had fallen off the bed and hit her head on the wheelchair. Patient slow to respond to name/small laceration on left brow. Skin tear on right arm and left wrist. Patient has altered mental status 911 call." On 12/25/2022 at 3:58 PM, V18 (LPN) states on 12/5/2022, V15 (CNA) came to V18 and said she had R1 sitting on the side of the bed about to be transferred to the wheelchair. V18 stated, "In the process of getting R1 dressed, V15 stated she turned her back to get a shirt for R1, and when she turned back around the resident was falling." V18 stated V15 said she grabbed R1 arms to keep her from falling, and R1 fell anyway. V18 stated V15 said R1 fell forward at an angle. V18 stated V15 came and got her, and they went to the room, and the resident was already in the	S9999		

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S9999	Continued From page 6	S9999		

wheelchair. V18 stated V15 got R1 up into the wheelchair. V18 stated R1 was very small and weighed about 90lbs, so it would not have been hard to get her into the wheelchair alone. V18 stated she did physical exam and found skin tears, and small cut to her eye brow, and then the whole area turned red the next day. V18 stated R1's skin tears to her arms probably happened when V15 grabbed R1's arms to try to keep her from falling. V18 stated R1 wasn't responding appropriately during the assessment. V18 stated she believed R1 was confused from the fall. V18 stated R1 was a fall risk, and has tried to get up without assistance previously. V18 stated considering R1 was a fall risk and impulsive at times, it was not appropriate for V15 to take her eyes off of R1 or turn her back to R1 while R1 was sitting at the side of the bed.

On 12/22/2022 at 1:26 PM, V2 (Director of Nursing/DON) stated the CNA was getting the resident dressed to get her up. V2 stated the CNA sat R1 "on the side of the bed as she always does and turned around to get a shirt "and when she turned back around, R1 fell forward and hit the wheelchair that was in front of her. V2 stated the CNA said she yelled for the nurse, and nurse came in, and her and nurse assisted R1 off the chair and into bed. V2 states R1 was one assist at that time.

On 12/23/2022 at 2:58 PM, V2 (DON) stated she expect the staff will follow the plan of care when caring for residents. V2 stated R1 was a fall risk and would try to transfer independently.

On 12/27/2022 at 2:25 PM, V1, Administrator, stated in an emailed letter the following: "the incident with (R1) occurring on 12/5/2022 is a fall that occurred while the resident was getting

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S9999	Continued From page 7 dressed with a nurse aide present. The resident attempted to get up, stumbled and hit her head on a wheelchair. The CNA turned away from the resident to get a shirt." On 12/23/2022 at 3:30 PM, V16 (Advanced Practice Nurse/APN) stated when she cared for R1, R1 was very anxious. V16 stated, "If the staff is sitting the resident at the bedside, the resident is knowing that her next move is to go into the chair." V16 stated staff should not be walking away from the resident when the resident is at the side of the bed. V16 stated, "If staff is helping someone with ADLs who is a fall risk, the expectation is to keep the resident safe and free from falling while they are helping the resident." The facility's fall evaluation Safety Guidelines, dated 11/28/2017, documents the following: the intent of the guideline is to ensure this facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident as identified through the following process: I. identification of hazards and risks, II Evaluation, III. Implementation, IV. Monitoring and V. Analysis. (B)	S9999		