STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012611	A. BUILDING: _____ B. WING _____	C 12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING HOM	940 MAPLE AVENUE HOMEWOOD, IL 60430

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S 000	Initial Comments Complaint Investigation 2299572/IL153898	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. 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. 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 requirements are not met as evidenced by: Based on interview and record review, the facility failed to develop a plan to prevent or reduce the risk of falling for a high risk fall resident also assessed to have bilateral lower extremity weakness. This affected 1 of 3 residents (R1) reviewed for fall prevention. This failure resulted in R1 having 2 falls in three days subsequently sustaining a left hip fracture. Findings Include: R1 is a 99 year old with the following diagnosis: vascular dementia, cognitive communication deficit, and reduced mobility. R1 admitted to the facility on 11/15/22 and discharged on 11/28/22. The Incident Report dated 11/25/22 documents R1 was observed sitting in the wheelchair near the nurse's station and the next time R1 was seen again, R1 was sitting on the floor in the hallway. R1 was admitted from the hospital for weakness after a UTI. R1 also has dementia and impaired safety awareness. R1 does not	S9999		

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S9999	Continued From page 2 remember what R1 was trying to do prior to the fall. R1 kept on attempting to stand without an assist and fell to the ground. A Nursing note dated 11/28/22 documents R1 was placed in the wheelchair in position at the nurse's station for supervision while the assigned CNA passed out dinner trays to the rest of the residents. R1 is confused and has a diagnosis of vascular dementia. R1 has a history of being a wanderer and a history of falls. During that shift, R1 stated multiple times to the nurse that R1 wanted to leave the facility and wanted to be taken home. Several attempts were made by staff to redirect R1 and to keep R1 occupied while attempting to do other duties. After dinner, the CNA washed R1 and put R1 to bed. The bed was in the lowest position. The call light was put within reach. R1 was made comfortable, and the TV was turned on for entertainment. The nurse and the CNA took turns rounding on R1. Around 7:21 PM, the nurse was informed by another CNA that R1 was lying in the floor in the hallway. This was an unwitnessed fall. R1 reported pain to the left hip and refused to allow staff to move R1. Transportation was arranged to take R1 to the hospital. R1's family and the doctor were notified. A Physician note dated 11/28/22 documents R1 is a wanderer and has been getting out of bed. Unfortunately, staff doesn't have the coverage to watch R1, and R1 was found at the end of the hall on the floor. It was an unwitnessed fall. R1 is complaining of left hip pain and was transferred to the hospital for further evaluation. The Incident Report dated 11/28/22 documents the nurse was answering call lights on the 200 hall when a CNA came and informed the nurse that R1 was down in the hallway of the 100 hall.	S9999		

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S9999	Continued From page 3 R1 reported having pain in the left hip. R1 had to be redirected multiple times by staff. R1 reported wanting to leave the facility that evening. R1 was washed and put to bed. R1 was checked on multiple times and appeared to be relaxing in bed without incident. The CNA and nurse were attending to other residents at the time of the unwitnessed fall. R1 was sent to the hospital for evaluation. R1 is alert and oriented to person only with periods of confusion. R1 has poor safety awareness, requiring frequent supervision. The Hospital Records dated 11/28/22 document R1 presented to the emergency room after having a fall and landing on a hard surface. R1 has a history of dementia and is not a reliable historian. R1's only complaint is left hip pain. R1 is able to wiggle toes and flex and extend the ankle on the left foot. There is no movement of the left hip secondary to pain. An X-ray of the left hip shows a left femoral neck fracture. R1 will be admitted to the hospital for medical clearance and then surgical procedure. On 12/15/22 at 3:47PM, V6 (Physical Therapist) stated, "We were working on balance and strength with R1. We were also working on getting in and out of bed and walking. I would say R1 had moderate to severe cognitive deficits. Nursing does the interventions, but we will communicate with them things that we find during our therapy sessions. R1 was a high fall risk due to R1's cognition, and not having a steady gait without an assistive device. We educate the staff on our concerns with what R1 has during therapy and told them that R1 needed supervision because she was not steady. R1 also had an issue with R1's knees giving out when R1 would walk. That is why we were working on strengthening and balance with R1."	S9999		

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S9999	Continued From page 4 On 12/15/22 at 4:02PM, V7 (CNA) stated, "I had R1 for the first fall. R1 was sitting in the geri chair at the nurse's station before dinner. R1 got up and started walking alone and just fell. R1 fell a couple feet from the nurse's station. I saw R1 go down. R1 didn't trip over anything; R1 just couldn't walk anymore and fell down. I was coming out of another patient room, and I was about 20 feet from R1. I was providing patient care for about 15 to 20 minutes and no one else was at the nurse's station. R1 is very active and has a wiggly gate. We try to keep eyes on her as much as possible, but we do have other residents we need to care for. I don't know what intervention was put in place after that for R1. We will try to just keep an eye on R1 and trade off with the other nurses and CNAs on the floors with who is watching R1. I don't think R1 was a high fall risk because I don't remember R1 having a yellow band on. R1 was able to do everything on R1's own. R1 just was a little wobbly." On 12/16/22 at 11:38AM, V8 (CNA) stated, "I was in another room doing patient care when R1 fell. I didn't see or hear the fall. I heard another staff member say R1 was on the ground in the hallway. R1 stays in the room 1XX which is right next to the nurse's station, and R1 ended up walking all the way down to room 1XX before R1 fell. That is in the middle of the hall. R1 got out of bed and walked down the hall after being put to bed around 7:30PM. I would say the fall was probably 30 or 45 minutes after that. Before that, R1 was sitting in a chair at the nurse's station. R1 is a busybody. We kind of just keep an eye out for R1 but we can't watch R1 and do patient care at the same time. R1 was just antsy. I'm not sure if R1 was a high fall risk. I don't remember it saying that in the chart. I was never told that R1 had any	S9999		

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S9999	Continued From page 5 other falls. The nurse would tell us if R1 had other falls in report. R1 was only steady on R1's feet for a couple steps then it would seem like R1 wants to go down. I think R1 was just weak. The nurse will tell you about the new interventions that are put in. I don't know what was put in after this fall or if R1 had any others." On 12/16/22 at 12:46PM, V12 (Nurse) stated, "I got report from the dayshift nurse, and she told me that the R1 normally has a sitter but that day the sitter did not show up. R1 was at the nurse's station when I got there, and I sat with R1 for a while the CNAs did their care and passed the dinner trays. After R1 was finished eating, the CNA went to lay R1 down in bed to put R1 to sleep for the night. We try to keep tabs on R1 and do the best we can. I had to start passing my medication on the other wing so I will check on R1 as I walked by. When I was on the other wing, passing my medication and another CNA came by and told me that they saw R1 on the floor. I immediately went to go assess R1 and she told me she was fine but when R1 tried to move, R1 had hip pain. R1 did have a history of falls and had a fall a couple days before. We were still doing neuro checks on R1 from the previous fall. I know R1 has dementia and goes in and out of confusion. I had to go finish passing my medication, and the CNAs had to go finish up with patient care for the other residents. R1's fall was not witnessed. I was not told how R1 walks. This was my first time with R1. I would say R1 was put down around 630 and probably just before 730, I was told R1 was on the ground. R1 made it all the way down to the middle of the hallway before falling down. We just look in the chart to see what (interventions) someone should have in place. I don't remember being told anything that R1 was weak, but I knew R1 was a	S9999		

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S9999	Continued From page 6 high fall risk because R1 already had another fall." On 12/20/22 at 11:04AM, V14 (Primary Physician) stated, "R1 is only alert and oriented times one. Physical therapy will eval the residents and help make suggestions on what is best for them. That is up to nursing and rehab to put in the interventions to help prevent the falls." On 12/20/22 at 11:18AM, V2 (DON) stated, "For this fall, R1 was found down in the hallway. When I interviewed the CNA, she said she put the bed in the low position, gave R1 the call light, and put the TV on to give her a little bit of light and background noise in the room. The CNA left the room and went to go collect the other trays and take care of the other residents. The nurse went to pass medication to other residents. A different CNA found R1 on the floor. For her the interventions were a low bed, monitor for assist to transfer and ambulate, reinforced need to call for assistance, report, any pain or new bruises that would suggest a fall, and physical therapy to evaluate and treat. Some of the interventions are put in at the admission time, others are put in after the physical therapy evaluation, and then other interventions are put in after a fall. Yeah, R1 was a high fall risk from admission. We consider anyone with dementia, unsteady gait, and needing more attention a high fall risk. Interventions are put in based on what type of fall occurred to prevent it from happening again." On 12/20/22 at 12:33PM, V3 (Nurse Manager) stated, "R1 has dementia, and is very impulsive. R1 has no regards to safety. The initial intervention for the fall is put in by the nurse. We make the interventions based off of what their diagnosis is along with the fall that occurred to	S9999		

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S9999	Continued From page 7 make it appropriate to prevent further fall." The Physical Therapy Evaluation and Plan of Treatment dated 11/16/22 documents R1 needs partial to moderate assistance with walking secondary to knees giving out. R1 exhibits uneven, step length, decreased accuracy of movements, and in adequate knee extension any instability. R1 has impaired right and left lower extremity strength. The Physical Therapy note dated 11/25/22 documents the right lower extremity has tendency to buckle down during ambulation. The Minimum Data Set (MDS) dated 11/21/22 documents a Brief Interview for Mental Status score as a 7 (severe cognitive impairment). Section G of the MDS dated 11/28/22 documents R1 needs an extensive one person, physical assist with bed mobility and locomotion on unit. An extensive two person physical assist with transferring and walking in the room is needed for R1. When moving from a seated to a standing position and when walking R1 is not steady and is only able to stabilize with staff assistance. The Care Plan dated 11/15/22 documents R1 is at risk for falls due to unsteady gait. The following interventions are documented on 11/15/22: provide assist to transfer in ambulate as needed, reinforce need to call for assistance, therapy, evaluation and treatment for orders, report development of bruises/pain/change in mental status/ADL function/appetite/neurological status per facility guidelines post fall. The following interventions are documented on 11/18/22: bed in low position. The following interventions are documented on 11/28/22: monitor for unassisted transfers. There are no documented interventions	S9999		

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S9999	Continued From page 8 regarding R1's weak lower extremities or R1's knees giving out while ambulating. The policy titled, "Falls Practice Guide," dated 11/2020 documents, "The purpose of the falls practice guide is to describe the process steps for identification of patient. Fall risk factors, and interventions and systems that may be used to manage falls ... Upon admission, review hospital, discharge records, transfer sheets or other data regarding the patient's history of, or risk factors for, experiencing a fall. Interview the patient and family or responsible party about the patient's history of falls, possible causes of those falls in interventions that did, or did not work to prevent further falls. Complete the patient admission/re-admission screen, answering the specific questions regarding the patient's history of actual falls and ongoing risk for falls. Some risk factors or conditions that may predispose a patient to a fall may include, but are not limited to: musculoskeletal conditions, that impair strength, history of falls, orthostatic, hypotension, depression, urinary or fecal urgency, visual, or hearing impairments, peripheral neuropathy's, history of vestibular, disease, unsteady gait, muscle weakness, syncope, stroke, transient, ischemic, attack, age, greater than 80 years, cognitive impairment, dementia, use of assistive devices, physical restraints, medication's, and physical environment ...Based on the findings of the MDS and the CAAs, following review of risk factors, environmental factors in other clinical conditions, the patient's initial care plan is updated or a comprehensive care plan is developed to include individualized patient interventions that focus on the patient's risk factors ... Interventions are clear, specific, and individualized for the patient's needs ... The care plan is revised as clinically indicated to meet the	S9999		

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S9999	Continued From page 9 patient's current needs." (A)	S9999		