| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6009096 | A. BUILDING: _____ B. WING _____ | 12/15/2022 |

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| S 000 | Initial Comments<br><br>Annual Health Survey | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>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:<br><br>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.<br><br>These Requirements were NOT MET as evidenced by:<br><br>Based on observation, interview and record review the facility failed to implement resident specific fall prevention interventions for a resident | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1 | S9999 | | |

with severe cognitive impairment for 1 (R6) of 5 residents reviewed for falls in the sample of 42. This failure resulted in R6 being transferred to the hospital's emergency department where he was diagnosed with a hip fracture and had subsequent hip surgery.

Findings include:

R6 is a 79-year-old male admitted to the facility on 03/09/2020 with diagnosis including but not limited to Chronic Obstructive Pulmonary Disease, Unspecified Asthma, Hypertension, Alzheimer's Disease, Major Depressive Disorder, and Dementia.

According to MDS (Minimum Data Set) dated 05/18/2022 under section C, R6 has BIMS (Brief Interview of Mental Status) score of 4 indicating severely impaired cognition. .

According to MDS (Minimum Data Set) dated 05/18/2022 under section G, all shows R6's functional status for transfers requires extensive assistance with one-person staff assist to transfer, walk in the room, and toilet use.

Fall risk assessment dated 05/13/2022 shows R6's fall risk evaluation score of 12, indicating very high risk for falls.

On 12/12/22 at 01:17 PM Surveyor observed R6 in his room. Bed placed against the wall, fall mat present on the right side of the bed. Bed in the lowest position with upper side rails up. Call light within R6's reach. R6's speech unintelligible, surveyor unable to conduct interview.

On 12/14/22 at 11:51 AM Surveyor interviewed V16 (Registered Nurse/ fall preventionist), V16

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| S9999 | Continued From page 2<br>stated, "One of the reasons why R6 suffered multiple falls withing this year (2022) is that R6 has gait imbalances and is very impulsive. R6 is often displaying unpredictable behaviors, like trying to remove his clothes while being assisted to the bathroom. R6 was evaluated for urinary tract infections several times; however, all came back with negative result". V16 stated, "When R6 was on the initial unit, he was placed right across from the nursing station. Additionally, R6 was encouraged to participate in day-care program to keep him occupied with multiple activities throughout the day. V19 (Psychiatrist) and the family were also involved in R6's care. Evenings and nights appeared to be the culprit of R6's fall problem. R6 had 12 fall incidents from the beginning of 2022. The hip fracture was suffered during one of his episodes of impulsiveness on 06/14/2022. R6 was attempting to get up without assistance. V17 (Certified Nursing Assistant) just rounded on R6 and offered toileting; around 1:50am V17 (CNA) and V18 (Licensed practical Nurse) found him on the floor". V16 stated, "R6 would ask at times to take him to the bathroom, and he used his call light, but it was inconsistent". V16 further indicated that R6 was transferred to secured memory care unit for more effective monitoring.<br><br>On 12/14/22 at 12:54 PM Surveyor interviewed V14 (LPN/ secured memory care unit staff), V14 stated, "R6 was transferred to the secured memory care unit about six months ago. R6 is on fall preventions that include bed in lowest position, fall mats, upper side rails up, frequent monitoring, at least every 2 hours but with him it's usually every 45 minutes to 1 hour, bed and chair alarm in place, and call light within reach. Additionally, R6 resides in the room right across from the nursing station". | S9999 | | |

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| S9999 | Continued From page 3<br><br>On 12/14/22 at 12:54 PM Surveyor interviewed V15 (Certified Nursing Assistant/ secured memory care unit staff), V15 stated, "R6 is on fall precautions. I check on him every 10 min, the door to his room is almost always open, so we can look at him pretty much constantly. R6 has fall mat beside his bed and chair alarm and bed alarm are in place".<br><br>Fall care plan dated 03/10/2020 reads in part, "R6 is at risk for falls, with interventions: educate R6 of the importance of calling staff if he needs assistance, create signs with instruction reminding R6 to use call light for assistance, keep call light within reach, remind R6 to ask for assistance".<br><br>Resisting Care care plan dated 09/16/2020 reads in part, "R6 exhibits symptoms of resisting care which is manifested by: getting up to go to the bathroom, with interventions: educate and remind resident to utilize call light, remind resident to ask for assistance form staff".<br><br>Per record review, R6 fell on 01/11/2022, 02/18/2022, 03/10/2022, 03/14/2022. 04/28/2022, 05/07/2022, 05/13/2022, 06/10/2022, 06/14/2022 while in the initial unit. R6 suffered hip fracture during 06/14/2022 fall incident. Additionally, R6 fell on 06/25/2022, 07/22/2022, and 10/10/2022 while in the secured memory care unit.<br><br>Per record review, hospital records dated 06/14/2022 at 01:01 PM reads in part, "[R6] sustained mechanical fall at nursing home earlier today resulting in left hip fracture. Orthopedic surgery has been consulted and plan is for operative repair later today". | S9999 | | |

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| S9999 | Continued From page 4<br><br>On 12/15/2022 at 09:49 AM, 10:54 AM, and 12:44 PM Surveyor attempted to interview V17 (Certified Nursing Assistant) via phone, no answer, voicemail left.<br><br>On 12/15/2022 at 09:51 AM, 10:56 AM, and 12:46 PM Surveyor attempted to interview V18 (Licensed Practical Nurse) via phone, no answer, voicemail left.<br><br>On 12/15/2022 at 09:53 AM Surveyor attempted to interview V19 (Psychiatrist), message left with receptionist, waiting for a call back.<br><br>On 12/15/2022 at 10:16 AM Surveyor received call back from V19 (Psychiatrist), V19 stated, "R6 is not cognitively appropriate to respond to fall preventions such as [but not limited to] educating of the importance of calling staff if he needs assistance, creating signs with instruction reminding to use call light for assistance, or reminding to ask for assistance. R6 is not cognitively aware and cannot retain information and process through what's appropriate and what's not".<br><br>"Legacy Healthcare Fall Occurrence Policy" dated August 3, 2016, reads in part, "It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions are reevaluated and revised as necessary. Ultimately, the Falls Coordinator may change the interventions provided by the nurse if the Falls Coordinator's investigation identifies a more appropriate intervention for the individual fall. The interventions will be reevaluated and revised as necessary".<br><br>(A) | S9999 | | |

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