STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002679	A. BUILDING: _____ B. WING _____	C 12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN VILLAGE CARE CENTER	400 SOUTH STATION ROAD GLEN CARBON, IL 62034

(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 Facility Reported Incident of 10/31/2022/IL153817	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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. These Requirements were not met evidenced by: Based on interview and record review, the Facility failed to ensure continued assistance with ambulation to prevent resident injury for 1 of 4 residents (R1) reviewed for falls, in the sample of 4. This failure resulted in R1 sustaining a fractured femur from falling while unattended. Findings include: R1's Care Plan dated 5/27/2022 documents, "I am at risk for falls due to dementia diagnosis, confusion, forgetfulness, severe impairment. I am up with assist using a walker or I use a wheelchair. I have tried to walk unassisted at	S9999		

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S9999	Continued From page 2 times." R1's Minimum Data Set (MDS) dated 10/31/2022 documents R1 required limited assistance for transfers and ambulation. R1's Care Plan dated 11/4/2022 documents, "I am at risk for pain and have exhibited signs of pain related to left hip fracture. I am on hospice at this time." The Facility Reported Incident dated 11/2/2022 documents, "Final Report on (R1) fall on 10/31/2022" and continues, "On 10/31/2022 during shift change, approximately 1505 (3:05 PM) a CNA (Certified Nursing Assistant) was ambulating with (R1) with her w/w (wheeled walker) in the hallway towards her room. There was another resident who is known to be a high risk for falls in her w/c (wheelchair) wander about the hallway going in another room. The CNA saw her and tried to verbally redirect her without success. The CNA told (R1) to wait right here and left her standing by the rail in the hallway while she assisted the other resident out of a room and redirected her back to the common area. When the CNA turned around (R1) was falling backwards to the floor. The nurse was summoned and assessed her. (R1) was assisted up with gait belt and 2 assist to her seated walker. She was then assisted to her bed. She was rubbing her left leg and when asked about pain, she said it hurt. Upon assessment her left leg was noted to be swelling and turned outward. (R1) was sent to the ER (Emergency Room) for evaluation and treatment. She was admitted to the hospital with a left femur fracture. (V4) was counseled to complete current ADL (Activities of Daily Living) with resident she was working with before assisting another resident."	S9999		

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S9999	Continued From page 3 R1's X-ray Report dated 10/31/2022 documents, "Findings: There is a comminuted (breaking of a bone into several small pieces and is the result of high velocity injuries, such as car accidents or falls from a height) intratrochanteric fracture of the proximal left hip with anterior displacement and varus deformity." R1's Care Plan dated 11/10/2022 documents, "I have some difficulty comprehending things and understanding others related to my dementia progression." R1's Care Plan was updated on 11/10/2022 and documents, "Now non-weight bearing left leg and on hospice. Intervention: Staff educated to stay with senior and complete ADL with that senior before trying to help another." R1's MDS dated 11/10/2022 documents, "Significant Change- Extensive assistance of two staff members for transfers. Ambulation- Activity did not occur." On 12/6/2022 at 1:30 PM, V4, Certified Nursing Assistant (CNA) stated, "(R1) walked by herself with a walker and supervision. I was taking her from the dining room to the hall. I noticed another resident going into someone elses' room. I asked her (R1) to stay right there and told her I'd be right back. I went to get the other resident and I heard, 'Ahh!' and turned back around and she was already going down. I couldn't catch her." On 12/6/2022 at 2:00 PM, V6, Licensed Practical Nurse (LPN), stated R1 used to walk with a walker prior to her fall but now requires a mechanical lift. V6 stated R1 fractured her left femur (large bone in the upper leg), her family	S9999		

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S9999	Continued From page 4 choose not to pursue surgery, and R1 was placed on hospice. On 12/7/2022 at 11:30 AM, V7, LPN, stated, "(V4) was taking (R1) to the bathroom. She was walking down the hall with her walker. Another resident, who is very unsteady, starting standing and (V4) didn't want her to fall. (V4) was probably an arms length away but (R1) suddenly went down. (V4) just wasn't close enough to catch her. I assessed her. She said her leg hurt and I noticed it wasn't aligned right. We called 911 and sent her out. She had a femur fracture. Her family didn't want her to have surgery due to her age, so they decided on hospice care." On 12/7/2022 at 2:23 PM V3, Medical Director, stated, "(R1) is demented (has impaired cognition). (R1) was told not to move (while the CNA helped another resident). (R1) was already declining but her decline was accelerated by the fall." On 12/8/2022 at 2:33 PM, V2, Director of Nursing (DON), stated, "She (R1) shouldn't have been left alone for any amount of time. It's hard to tell if her fall could have been prevented since (R1) walked by herself. (V4) was trying to prevent another resident who is known for falling from falling." The Facility's Fall Prevention Policy and Procedure dated 3/1/2018 documents, "Objective-Reduce the risk of resident falls and possibly injury." (A)	S9999		