STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015622	A. BUILDING: _____ B. WING _____	C 09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENGLOW INN	1200 EVENGLOW LANE PONTIAC, IL 61764

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S 000	Initial Comments Facility Reported Incident of 8/26/23/IL163956	S 000		
S9999	Final Observations Statement of Licensure Violation: 330.710a) 330.710c)3)A)B)C)F Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. c) The written policies shall include, but are not limited to, the following provisions: 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs.	S9999	Attachment A Statement of Licensure Violations	

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B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling.

C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment.

F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident.

These requirements are not met as evidenced by:

Based on observation, interview, and record review the facility failed to conduct thorough fall investigations to identify root cause and develop post fall interventions, implement post fall interventions, and update care plans to include falls and fall interventions for three residents (R1, R2, R3) reviewed for falls in the sample list of three.

Findings include:

1.) R1's Diagnoses List dated 9/6/23 documents R1 has Dementia. R1's Assessment dated 8/5/23 documents R1 is alert and oriented to person with short- and long-term memory impairment. R1 has an unsteady gait and requires supervision. R1 requires assistance with bed mobility, transfers and toileting. R1 is incontinent of urine.

R1's Nursing Notes document on 8/26/2023 at

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S9999	Continued From page 2 11:00 PM R1's chair alarm sounded and R1 was found lying on the floor in front of R1's recliner. R1 was on R1's left side, head facing the window, and R1's arm bent behind R1. R1 had a left eyebrow laceration. R1 complained of left arm and left knee pain. R1 was transported by ambulance to the emergency room. On 8/26/23 at 9:59 PM R1 was restless during the shift and worried about R1's family. R1's family was called and spoke with R1 on the telephone. A urine sample was collected and sent to the laboratory. R1's Fall investigation provided by V2 Director of Nursing documents R1 was found on the floor in front of R1's recliner at 11:00 PM on 8/26/23. R1 was lying face down with R1's left arm underneath of R1. R1 had a laceration to the left eyebrow. R1 was sleeping in R1's recliner per usual and was toileted within an hour prior to the fall. Testing in the emergency room showed facial fractures, questionable 9th and 10th rib fractures, soft tissue swelling with hematoma (bruising) to the left knee, zygomatic arch fracture, and a left humerus fracture. There is no documentation what staff were interviewed to determine the time R1 was last checked on and toileted prior to the fall. This investigation does not identify the root cause of R1's fall. On 9/6/23 at 1:20 PM V2 stated R1 fell around 11:00 PM and was found by the Certified Nursing Assistants (CNAs) lying on the floor in R1's room face down. V2 stated the CNAs do rounds at 10:00 PM and R1 would have been toileted at that time. 2.) R2's Diagnoses List dated 9/6/23 documents R2 has Dementia. R2's Assessment dated 4/6/23 documents R2 is alert and oriented to person and	S9999		

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place and has short- and long-term memory impairment. R2 has impaired balance and requires assistance with toileting.

R2's Nursing Note dated 5/5/23 at 12:12 PM documents at 9:20 AM staff heard a loud noise and found R2 lying on R2's back in the West Dining Room. R2 had a large amount of blood under R2's head, and bleeding subsided once R2 sat up. A hematoma was noted and ice was applied. At 11:30 AM staff washed R2's hair and found a laceration approximately 3 centimeters. R2 was transported by ambulance to the local emergency room.

R2's fall investigation dated 5/9/23 provided by V2 documents R2 fell in the dining room on 5/5/23 at 9:20 AM. R2 had a 3 centimeter "V shaped" laceration to the back of the head. R2 was treated in the emergency room and received 7 staples to close the laceration. R2 had shoes/socks on and no environmental hazards at the time of the fall. R2 was toileted at 8:45 AM. There is no documentation what staff were interviewed to obtain this information. R2 attempted to self-transfer from the chair, lost balance and fell. There is no documentation that new post fall interventions were implemented after this fall.

R2's Resident Care Guide dated 2/7/23 documents to assist R2 to the bathroom every two hours and at least twice during the night. This guide has not been updated to include R2's fall or post fall interventions following R2's fall.

V2 reviewed R2's fall and stated R2 had an unwitnessed fall with head injury and received 7 staples to the back of her head. V2 stated no root cause was identified, but it was a lack of safety awareness. V2 stated there were no new post fall

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interventions implemented after R2's fall. We had previously tried a chair alarm, but if the resident is afraid of the alarm or it causes them to not stand up then it is considered a restraint and we don't use it. V2 confirmed R2's care plan does not identify R2's fall with major injury on 5/5/23 or any new interventions after that fall.

3.) R3's Diagnoses List dated 9/6/23 documents R3 has Dementia. R3's Assessment dated 8/15/23 documents R3 is alert and oriented to person and has short/long term memory impairment. R3 has an unsteady gait and requires supervision and requires assistance with toileting.

R3's Nursing Note dated 8/18/23 at 8:54 AM documents R3 fell at 7:30 AM. R3 attempted to get up from R3's recliner without lowering the foot rest, and apparently fell to the floor. This note documents a chair alarm will be implemented.

R3's Fall Investigation provided by V2 documents on 8/18/23 at 7:30 AM staff responded to an alarm sounding and found R3 lying on the floor in front of R3's recliner. R3 had attempted to stand without staff assistance and without using R3's wheeled walker causing R3 to lose balance. This form documents R3's current fall interventions included the use of bed and chair alarms, and no new post fall interventions were implemented.

R3's Fall Investigation provided by V2 documents R3 fell on 8/27/23 at 7:20 PM. R3 was found sitting on the floor in front of the recliner in the South side television area. There is no documentation as to when R3 was last observed or toileted prior to R3's fall, or that a chair alarm was in use. The root cause is identified as R3

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standing and losing balance and there were no new interventions implemented.

R3's Physician Order with start date of 8/18/23 and stop date of 8/25/23 documents to use a chair alarm. There is no documentation in R3's medical record as to why this alarm was discontinued.

R3's Fall Risk and Intervention Assessment/Observation dated 9/6/23 at 12:12 PM documents R3 is at moderate risk for falls and includes the use of a chair alarm as a current intervention.

R3's Resident Care Guide dated 1/2/23 documents to assist R3 to the restroom every two hours and twice during the night. This guide has not been updated with R3's falls or any new post fall interventions for R3's falls on 8/18/23 and 8/27/23.

On 9/6/23 at 10:00 AM, 10:15 AM, and 11:11 PM R3 was sitting in a recliner in the television area and a chair alarm was not in place.

On 9/6/23 at 11:00 AM V10 Universal Caregiver and V13 Registered Nurse stated R3 does not use a chair alarm.

V2 reviewed R3's falls and stated the chair alarm was added as a post fall intervention on 8/18/23. The root cause was that R3 attempted to stand on R3's own and lost balance. The root cause of the 8/27/23 fall was that R3 got up on R3's own and lost R3's balance. V2 stated the chair alarm order was discontinued and V2 believes it was because R3 was afraid of the alarm and it wasn't working for R3. V2 stated staff should document

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S9999	Continued From page 6 that in a progress note. V2 confirmed R3's care plan has not been updated with any new fall interventions after R3's falls on 8/18/23 and 8/27/23. V2 stated V2 has provided all documentation for R1's, R2's, and R3's fall investigations. V2 stated V2 interviews the resident, nurses and Certified Nursing Assistants regarding resident falls. V2 stated V2 does not document the information or questions asked. About a month ago the facility started using a new form that documents details prior to the fall. V2 stated V2 looks at the care plan to see what current interventions the resident has. V2 confirmed there is no documentation in R1's, R2's, and R3's fall investigations of what staff were interviewed to determine the time the resident was last seen and toileted prior to the falls. V2 stated V2 is responsible for updating the resident care plans to include falls and post fall interventions. V2 stated V2 is not always timely in updating the care plans. The facility's undated Procedure for a Resident with a Fall documents to obtain witness statements, update the resident's plan of care with new post fall interventions, and the interdisciplinary team will review falls to make recommendations. (B)	S9999		