STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001127	A. BUILDING: ____ B. WING ____	C 02/03/2023

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S 000	Initial Comments Complaint Investigation 22910214/IL154628 2299909/IL154294	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.1220b)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	S9999	Attachment A Statement of Licensure Violations	

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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.

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.

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These requirements were Not Met as evidenced

Based on interview and record review, the facility failed to supervise a cognitively impaired resident who was identified as a fall risk and develop and implement a plan with effective interventions to prevent or reduce the risk of future falls. This affected 2 of 3 residents (R1, R11) reviewed for fall prevention. The failure resulted in (R1) having multiple unwitnessed falls, sustaining left lateral rib fractures and scalp swelling.

Findings include:

1. R1 has diagnoses of Dementia, weakness, abnormalities of gait/ mobility, lack of coordination, abnormal posture, unsteadiness on feet, repeated falls, other symptoms/signs involving cognitive functions and awareness. R1's brief interview for mental status dated 10/4/22 documents a score of six which indicate severe impairment. Section G (functional status) documents: R1 requires limited assistance with one-person physical assist for walking in room and transfers. Balance during transitions and walking, moving from a seated to standing position, walking, moving on and off toilet and surface transfer between bed, chair and or wheelchair documents: Not steady, only able to stabilize with staff assistance. Fall observation dated 2/26/22 documents: high risk.

(8/17/22 fall)

On 12/22/22 at 10:47am, V5 (Restorative Director) said that R1 had an unwitnessed fall in the bathroom which resulted in fracture ribs. No interventions were documented.

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S9999	Continued From page 3 Nursing note dated 08/17/2022 documents: Resident (R1) had an unwitnessed fall while in the bathroom. R1 complained of left hip/rips pain. All safety measures implemented, will continue with plan of care. Event report dated 8/17/22 documents: R1's location prior to the fall- unknown, mental status-confused and respond to name/pain. Left rib 2 view x-ray dated 8/18/22 documents: Acute left lateral rib fractures. Care plan dated 8/19/2020 documents: Resident (R1) has a history of falling related to dementia, abnormal posture and unsteadiness on feet -No interventions documented for R1's fall on 8/17/22. (11/11/22 fall) On 12/22/22 at 10:47am, V5 (Restorative Director) said, R1 had an unwitnessed fall while attempting to get into the wheelchair from the bed. R1's wheelchair was unlocked. R1 slipped. Physical therapy was consulted for strength training, toning, gait training and mobility device. R1 attempts to self-transfer frequently. R1 knows she needs to notify staff, but she doesn't. Education was not an effective intervention related to R1's diagnosis of Dementia and cognitive impairment. R1 should have been given a (Brand type) mattress for attempting to transfer from the bed. Nursing note dated 11/11/2022 (6:20am) documents: Writer notified that patient (R1) was on the floor at bedside. Patient (R1) stated "the chair got away from me." Wheelchair noted with wheels unlocked. Nursing note dated 11/11/2022 (12:51pm)	S9999		

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S9999	Continued From page 4 documents: R1 observed attempting to transfer self from bed to wheelchair, educated on safety, encourage to pull call light for assist. Progress note dated 11/11/2022 (1:48pm) documents: R1 reported she slipped out of bed while attempting to transfer to the wheelchair. Maximum education to R1 regarding wheelchair safety with correct height of bed when transferring. Maximum education for R1 to reach out for help via call light when transferring. R1 reported, "Well, this old bird is just going to keep on going." Event report dated 11/11/22 documents: R1 had an unwitnessed fall. R1 was found on the floor. Fall from bed. Care plan dated 8/19/2020 documents: Resident (R1) has a history of falling related to dementia, abnormal posture and unsteadiness on feet. (start date 11/14/22) -Provide max education regarding w/c (wheelchair) safety including w/c brake lockage, safety with transfers and safety with correct height of bed when transferring. Reiterate to resident to reach out for help with call light when transferring. (12/01/22 fall) On 12/22/22 at 10:47am, V5 (Restorative Director) said, R1 had an unwitnessed fall on 12/1/22 around 6am. R1 was walking from the bathroom, while dripping urine and slipped in the urine. R1 sustained a lump on the head. R1's intervention was to provide toileting assistance after meals and before bed. The intervention should have been to provide assistance on toileting upon waking.	S9999		

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Physician note dated 12/01/22 (6:24am) document: Patient (R1) fell from the wheelchair to the floor. R1 sustained a swelling on the scalp.

Nursing note dated 12/01/2022 (6:53am) documents: Upon rounds R1 was noted on floor in supine position. During assessment writer noted a lump on R (right) side of head. R1 stated she was trying to transport to restroom.

Event report dated 12/01/22 documents: R1 had an unwitnessed fall. Functional status evaluation compared to baseline documents: need more assistance with ADL care. Fall precaution, low bed, frequent rounding in place. R1 refuses to comply despite understanding.

Care plan dated 8/19/2020 documents: Resident (R1) has a history of falling related to dementia, abnormal posture and unsteadiness on feet -No interventions documented for R1's fall on 12/1/22.

Nursing noted dated 12/04/22 documents: R1 noted up walking around without wheelchair. R1 needs reinforcement.

(12/8/22 fall)

On 12/22/22 at 10:47am, V5 (Restorative Director) said that R1 had a witnessed fall on 12/8/22. R1 slid of out the wheelchair. The witness was not able to get to R1 in time to prevent the fall. R1 verbalized she hit her head. Intervention was to provide toilet assistance before bed and upon waking. The intervention should have been anti-skid pad (Brand) for R1's wheelchair.

Nursing note dated 12/08/2022 documents: R1 was observed sitting upright on bedroom floor at

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S9999	Continued From page 6 approximately 9:00am. R1 verbalized that she hit the back of her head. R1's roommate verbalized she witnessed patient (R1) sliding out of the chair. Event report dated 12/08/22 documents: Functional status evaluation compared to baseline documents: need more assistance with ADL care, fall (one or more) and generalized weakness. Pain evaluation documents; new, sharp, 3/10. Care plan dated 8/19/2020 documents: Resident (R1) has a history of falling related to dementia, abnormal posture and unsteadiness on feet -No interventions documented for R1's fall on 12/8/22. Hospital paperwork dated 12/8/22 documents: R1 was (AOx1) alert and oriented times one. R1 said, "I was eating and slipped onto the ground." R1's roommate called the nurse. Facility staff said, R1 tries to get up unassisted. R1 fell next to her bed. (12/10/22 fall) On 12/22/22 at 10:47am, V5 (Restorative Director) said that R1 had a fall on 12/10/22. R1 was observed sitting in front of unlock wheelchair. R1 slid off the chair while trying to sit down. Intervention was to ensure floor free of glare, liquids and foreign objects. This was not an effective intervention. R1 would not have been able to lock the wheelchair due to cognitive impairment. The IDT comes up with interventions after a fall. I am responsible for putting those intervention in place, and making sure they are effective, and educating staff. If the interventions put in place don't work/prevent a future fall, we come up with new intervention.	S9999		

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S9999	Continued From page 7 Nursing note dated 12/10/2022 documents: R1 was observed sitting upright in front of her unlocked W/C (wheelchair) on her bathroom floor. The patient (R1) stated, "I slide off the chair while trying to sit down." Event report dated 12/10/22 documents: was fall witnessed-no. Care plan dated 8/19/2020 documents: Resident (R1) has a history of falling related to dementia, abnormal posture and unsteadiness on feet -No interventions documented for R1's fall on 12/10/22. Fall policy revised 8/2008 (Treatment/Management) documents: based on the proceeding assessment, the staff and physician will identify pertinent intervention to try to prevent subsequent falls. 2. R11 was admitted with diagnoses of difficulty in walking, cognitive communication deficit and weakness. Fall risk observation dated 12/22/22 documents: R11 is a high fall risk related to visual impairments, balance problems while standing. Care plan dated 12/23/22 documents: R11 at risk for falling related to decreased mobility, glaucoma and weakness: keep bed in lowest position with brake locks, keep call light in reach at all times, keep personal items and frequently used items within reach. Minimal data set section G (functional status) dated 12/27/22 documents: R11 requires extensive assistance with one-person physical assist with transfers and walking in the room. Balance with walking and turning around: not steady, only able to stabilize with staff assistance.	S9999		

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S9999	Continued From page 8 Fall event dated 12/25/22 at 1:30am documents: R11 had unwitnessed fall in room. R11 was noted lying on his side on the floor in front of his bed. R11 was help to the washroom and back to bed via walker. Fall event dated 12/26/22 at 10:05am documents: R11 had an unwitnessed fall. R11 had intermittent confusion. Care plan dated 12/26/22 documents: Give R11 verbal reminders not to ambulate/transfer without assistance. Keep call light in reach at all times. Obtain physical therapy consult for strength training, toning, positioning, transfers, gait training, mobility devise. Place R11 in restorative programs, provide proper, well-maintained footwear, provide transfer assistance from bed to wheelchair. On 12/30/22 at 3:39pm, V5 (Restorative Nurse), R11 was a fall risk related to balance. R11 had an unwitnessed fall on 12/25/22. R11 was self-ambulating. R11 reported falling while trying to go the washroom. The interventions put in place was not effective. On 2/3/23 at 11:29am, V5 said, R11's had a fall on 12/26/23, R11 rolled out of bed. Fall policy revised 8/2008 (Treatment/Management) documents: based on the proceeding assessment, the staff and physician will identify pertinent intervention to try to prevent subsequent falls. (B)	S9999		