PRINTED: 02/23/2023 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ IL6001044 01/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1201 NORTH ALTON** LEBANON CARE CENTER LEBANON, IL 62254 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S 000 **Initial Comments** S 000 Annual Licensure and Certification Survey S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest

practicable level of independent functioning, and

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6001044			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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S9999	Continued From pa	age 1	\$9999	2. €	19 E	12 [1	
3	restrictive setting be needs. The asses the active participa	ge planning to the least ased on the resident's care sment shall be developed with tion of the resident and the or representative, as	20		8 w		
() 2	and services to attempted and services to attempted and the process well-being of the research resident's complant. Adequate and care and personal	all provide the necessary care ain or maintain the highest al, mental, and psychological esident, in accordance with mprehensive resident care d properly supervised nursing care shall be provided to each te total nursing and personal resident.					
	care shall include, and shall be practi seven-day-a-week 6) All necess to assure that the i as free of accident nursing personnel	basis: ba	3		100 miles		
H H	This REQUIREME	NT is not met as evidenced by	<i>:</i> :			22	
3: X	failed to provide su of 7 residents (R22 sample of 24. This multiple falls susta	v and record review, the facility apervision to prevent falls for 12) reviewed for falls in the failure resulted in R22's ining fractures of left radius s on 2 separate occasions.		PR 55 88			
	Findings include:			W ===			

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: IL6001044 **B. WING** 01/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 NORTH ALTON LEBANON CARE CENTER LEBANON, IL 62254 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 2 S9999 R22's Face sheet documents admission date of 8/14/2015. R22's Cumulative Diagnosis Log dated 10/1/2015 documents diagnosis of Dementia with Behavioral Disturbances, Unspecified Psychosis. Parkinson's, Fahr's Syndrome, Osteoarthritis. Seizures. R22's Minimum Data Set (MDS) dated 7/7/2022 documents R22 is severely cognitively impaired, requires extensive assist with walking in room, walking in corridor, transfers, and toilet use. R22's MDS also documents balance is not steady, only able to stabilize with staff assistance for walking and all transitions. R22's fall risk assessments dated 7/7/2022 documents R22 has a fall risk score of 17, R22 is at high risk for falls. The facility fall log documents R22 sustained falls on 8/3/2022, 11/4/2022, 12/3/2022, 12/4/2022, 12/20/2022, and 1/7/2023. R22's A.I.M (Assess, Intercommunicate, Manage) for Wellness note, dated 8/3/2022 at 11:15 AM. documents R22 was found in her bathroom on the floor. R22 complained of pain to left elbow. R22's hospital x-ray results, dated 8/3/22, document a non-displaced fracture of the left radius. R22's QA (Quality Assurance) Progress Notes, dated 8/4/22, documents root cause of R22's fall related to poor footwear and cluttered room. R22's fall risk assessments dated 11/4/2022

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lose her balance. The staff has been good to

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S9999	check her frequent dining room."  The Facility's undar procedure docume resident safety and falls; decrease falls wishes/desires for mobility. (Facility co	age 5 Ity and take her to eat in the sted Fall Prevention policy arents, Policy: "To provide for I to minimize injuries related a and still honor each reside maximum independence an orporate) has established a to check those at risk."	nd I to ent's				
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