Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006266	A. BUILDING: ________ B. WING ________	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONMOUTH NURSING HOME	117 SOUTH I STREET MONMOUTH, IL 61462

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S 000	Initial Comments Facility Reported Incident of 1/7/23/IL155576	S 000		
S9999	Final Observations Statement of Licensue 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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	Attachment A Statement of Licensure Violations	

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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 as evidenced by:

Based on interview and record review, the facility failed to investigate a resident fall, failed to initiate new fall prevention interventions in response to resident's falls, and failed to ensure previously existing interventions to prevent falls were in place for one of three residents (R1) reviewed for falls in the sample of four. This failure resulted in R1 sustaining repeated falls with multiple injuries including the following on 1/7/2023: Left Femoral Neck Fracture requiring surgical repair and Subdural Hematoma which required surgical drain placement.

Findings include:

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S9999	Continued From page 2 The facility's "Fall Risk Assessment" Policy, revised March 2018, documents the facility will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. This policy states "Interpretation and Implementation 1. Upon admission, the nursing staff and the physician will review a resident's record for a history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time." "7. The staff, with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, Activities of Daily Living (ADL) capabilities, activity tolerance, continence and cognition." "9. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable." The facility's "Falls and Fall Risk, Managing" Policy, revised March 2018, states, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling." "Fall Risk Factors: f. Footwear that is unsafe or absent." "Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with input from the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls." "5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or	S9999		

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S9999	Continued From page 3 corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. 7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g. hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling." "Monitoring Subsequent Falls and Fall Risk 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling." "3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. 4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls." The facility's "Accidents and Incidents-Investigating and Reporting" Policy, revised August 2018, states, "All accidents or incidents involving residents, employees, visitors, vendors, etc, occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation 1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included on the Report of Incident/Accident form: a. The date and time the accident or incident took place; b. The nature of the injury/illness (e.g., bruise, fall, nausea, etc.); c. The circumstances surrounding the accident or	S9999		

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S9999	Continued From page 4 incident; d. Where the accident or incident took place; e. The name(s) of witnesses and their accounts of the accident or incident; f. The injured person's account of the accident or incident; g. The time the injured person's Attending Physician was notified, as well as the time the physician responded and his or her instructions; h. The date/time the injured person's family was notified and by whom; i. The condition of the injured person, including his/her vital signs; j. The disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.); k. Any corrective action taken l. Follow-up information; m. Other pertinent data as necessary or required; and n. The signature and title of the person completing the report." "8. Incident/Accident reports will be reviewed by the Safety Committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities and to ascertain a possible root cause for the fall. 9. The IDT (Interdisciplinary Team) will review the fall and investigative material and make recommendations to possible prevent further occurrences. 10. The Care Plan will be updated to reflect the event and the recommendations of the IDT." R1's Hospital History and Physical, dated 10/17/22, prior to R1's facility admission, documents R1 has had multiple hospitalizations for falls, has had struggles with multiple falls at home, and had presented for a fall resulting in a thoracic compression fracture for which R1 was admitted for pain control. R1's Facesheet documents R1 admitted to the facility on 10/25/22 with diagnoses to include but not limited to: Parkinson's Disease, Cerebral Infarction, Unspecified Falls, Weakness,	S9999		

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Dizziness, Giddiness, Anxiety Disorders, Dementia, Epilepsy, Unspecified Injury of Head, Wedge Compression Fracture of Unspecified Thoracic Vertebra, and Subsequent Fracture with Routine Healing. This Facesheet documents R1's most recent hospital stay was 1/7/23-1/17/23.

R1's Census Report, dated 1/27/23, documents R1 originally admitted to the facility on 10/25/22 and was discharged from the facility on 1/7/23 and returned on 1/17/23.

The facility's Historical Incident Log, undated, documents R1 had unwitnessed falls on 11/17/22, 12/16/22, 12/19/22, 12/20/22, 1/3/23 and 1/7/23.

R1's Minimum Data Set (MDS) Assessment documents R1 with a Brief Interview for Mental Status score of 10/15, indicating moderate cognitive impairment. This same MDS Assessment documents R1 requires extensive assistance of two plus person physical assist for bed mobility, transfers, walking in room, and toilet use and requires extensive assist of one person physical assist for dressing.

R1's Admission Fall Risk Data Collection, dated 10/25/22, documents R1 is at a high risk for falls.

R1's Fall Risk Data Collection, dated 10/26/22, documents the assessment was completed due to R1 having an unwitnessed fall in the facility on 10/26/22 and documents R1 is at a "High Risk" for falls. This same assessment documents "Fall Needs" Interventions as: "Call don't Fall" sign; Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; Ensure personal items are within reach; Ensure that the resident is wearing appropriate footwear; Gripper Socks; and PT/OT (Physical

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S9999	Continued From page 6 Therapy/Occupational Therapy) evaluate and treat as ordered and PRN (as needed). R1's Current Care Plan states, "(R1) is at risk for falls, (R1) has a history of falls and has had several falls in the facility. (R1) is confused and is unaware of safety issues. (R1) is impulsive and will not ask for assistance nor will (R1) wait for assistance." The following interventions are documented with an initiation date of 10/26/22: Call don't Fall sign, Be sure (R1's) call light is within reach and encourage (R1) to use it for assistance as needed; Ensure personal items are within reach; Gripper Socks; and PT/OT (Physical Therapy/Occupational Therapy) evaluate and treat as ordered and PRN (as needed). R1's Health Status Note on 10/26/2022 at 8:58 AM documents R1 is alert but confused and that R1 has been verbally and physically abusive to staff. R1's Health Status Note on 10/26/2022 at 12:25 PM documents R1 had gotten out of R1's bed and walked into the bathroom without assistance. R1's Incident Report on 10/26/22 at 3:45 PM documents R1 had an unwitnessed fall in R1's room after ambulating without assistance. This same form documents R1 was transferred to the local area hospital for evaluation and documents R1 was educated to use the call light to call for assistance. R1's Incident Report on 11/17/22 documents R1 was attempting to transfer self to wheelchair and fell onto the floor on R1's buttocks. R1's Health Status Note on 11/17/22 at 1:35 PM, documents R1 was attempting to self-transfer into	S9999		

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S9999	Continued From page 7 R1's wheelchair when R1 lost balance and fell to the floor. This same note states, "Will place a Call Don't Fall Sign in room to prevent a similar incident." R1's current Care Plan states, "Call Don't Fall sign in room within sight" with an initiation date of 11/17/22. R1's Care Plan did not document a new intervention in response to R1's 11/17/22 fall to prevent further falls, nor to ensure R1's safety in the event of further falls. R1's Incident Report on 12/16/22 at 4:45 PM documents that R1 was ambulating without assistance. R1 was found on the floor in front of R1's recliner chair. This same report documents R1 stated R1 hit her head during the fall and there was a "small dime size area on the back of (R1's) head." Resident Description states, "(R1) stated that (R1) was trying to get up to get her bells that were on (R1's) wheelchair because she could not reach her call light. (R1) stated she had hit the back of her head on the floor when she fell." Immediate Action Taken is documented as R1 was given a double call light in case one of them should be out of reach for R1. This same report states, "(R1) reaching over for bells that were on her wheelchair and slipped out of her chair due to her call light being thrown over on her bed." On 2/1/23 at 11:15 AM, V2 (Director of Nursing) stated that the facility thought that there was an issue with the resident call light system, so the residents were given bells to use while the call light system was being investigated by maintenance. V2 stated that two call lights were then added to R1's room. One for R1's recliner chair and one for R1's bed.	S9999		

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R1's Health Status Note on 12/16/2022 at 9:53 PM, states, "(R1) tried to transfer herself again, lost her balance and landed on her bottom. No injuries, bruising, etc. ROM WNL (Range of Motion within normal limits). (R1) is already on neuros (neurological checks) d/t (due to) prior incident. (R1) was transferred back into her wheelchair and brought up to the nurses station. Will monitor."

As of 1/27/23 at 11:50 AM, R1's medical record did not contain documentation that an Incident Report, investigation to determine a root cause, or a newly implemented fall prevention intervention was created for R1's second fall on 12/16/22.

On 1/27/23 at 11:58 AM, V2 (Director of Nursing) stated, "The resident's nurse would initiate the Incident Report and then it would be reviewed by IDT (Interdisciplinary Team). There is no QA (Quality Assurance) doc (document) for that fall."

On 1/27/23 at 4:26 PM, V3 (Registered Nurse) stated that on 12/16/22, V3 worked from 2 PM-10 PM. V3 stated that V3 received R1 from V4 (Licensed Practical Nurse) halfway through V3's shift. V3 stated that V4 had reported to V3 that R1 had fallen earlier on V4's shift. V3 stated that right at (third) shift change, it was reported to V3 that R1 had fallen again. V3 stated that V3 assessed R1 while R1 was still on the floor and there were no obvious signs of injury. V3 stated that V3 wrote in R1's Progress Notes about R1's fall but did not create an Incident Report. V3 stated that an Incident Report should have been created regarding R1's fall but that V3 had passed it onto the next shift nurse to create but it was not done. V3 stated that R1 would be noncompliant at times and would tell staff, "I'm

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not waiting for you. I can do it myself." in regards to getting help with mobility.

On 1/31/23 at 9:24 AM, V2 stated that R1's nurse (V3) should have stayed over her shift to create the Incident Report for R1's second fall on 12/16/22 since V3 was R1's nurse at the time of R1's fall. V2 stated if the facility had known about R1's second fall on 12/16/22, a new fall prevention intervention would have been added.

R1's Incident Report on 12/19/22 at 6:30 AM states, "Heard a crash and then yelling. Upon entering the room, (R1) noted to be on the floor at end of the bed between bed and closet lying on her back. (R1) had no shoes on. (R1) hit her head on the floor causing a large hematoma. Large puddle of urine on floor under bed and bed was soaked." This same report documents a root cause of "attempting to transfer self with improper footwear." Predisposing Situation Factors are documented as "Ambulating without Assist" and "Improper Footwear." Injuries at the time of incident is documented as "Hematoma Top of Scalp."

R1's current Care Plan did not document a new intervention in response to R1's 12/19/22 fall to prevent further falls, nor to ensure R1's safety in the event of further falls.

R1's Health Status Notes on 12/19/2022 at 11:54 AM states, "(R1) has increased confusion this shift. (R1) has been having delusions. (R1) was talking to a wall.(R1) is making statements that make no sense. (R1) has been caught three times this morning transferring self." and also documents that a Urinalysis is pending.

On 1/31/23 at 9:30 AM, V2 verified that "gripper

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S9999	Continued From page 10 socks" and "ensure that (R1) is wearing appropriate footwear" were interventions previously initiated onto R1's Care Plan on 10/26/22 when R1 was determined to be a high risk for falls. On 2/1/23 at 11:47 AM, V7 (Registered Nurse) stated that on 12/19/22 around 6:30 AM, V7 was alerted that R1 was on the floor. V7 stated that R1 was lying on the floor at the foot of R1's bed and that R1 had been incontinent of urine. V7 stated that R1 was saying that R1 was trying to get clothes out of R1's closet. V7 stated that R1 was not wearing shoes or socks at the time of R1's fall. V7 stated that V7 recalled palpating a large hematoma on R1's head after the fall. V7 stated that R1 would often try to transfer herself without staff assistance. R1's Incident Report on 12/20/22 at 6:30 AM documents R1 slid out of R1's recliner onto R1's buttocks on the floor. "Immediate Action Taken" states "(R1) requires frequent reminders to use call light and not transfer self. Call Don't Fall sign placed in room as a visual reminder to call for help." R1's Current Care Plan documents "Call Don't Fall Sign" intervention was revised on 12/20/22 but did not document a new intervention in response to R1's 12/20/22 fall to prevent further falls, nor to ensure R1's safety in the event of further falls. R1's Incident Report on 1/3/23 at 4:05 PM documents R1 was attempting to transfer self from bed to chair to go to the bathroom. R1 was found lying on R1's back in front of R1's bed. R1's Incident Report on 1/7/23 at 8:00 AM states,	S9999		

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S9999	Continued From page 11 "Incident Description: V5 (LPN) was one room away when I heard a loud crash and screaming. I went to (R1's) room and found her on the bathroom floor on her back. (R1) was screaming in pain and for help. (V5) called for help from other staff. (R1) stated that (R1) walked to the bathroom and peed all the way there and fell. Immediate Action Taken: Staff cleaned the urine off the floor. (R1) was assessed for injuries. (R1) had a hematoma on back of head measuring 1.5 x 2 cm/centimeters. (R1) was placed in bed by three staff members. Upon further assessment, left leg was shorter than right leg and a raised area appeared on left hip. (R1) continued to holler in pain. Vitals were taken. Power of Attorney notified, (V2) was notified, 911 was called and V6 (R1's Physician) was notified. Ambulance arrived around 8:20 AM to take (R1) to ER (Emergency Room) to be assessed. Intervention will be toileting every two hours when awake." Predisposing Situation Factors are documented as "Ambulating without Assist" and "Improper Footwear." On 2/1/23 at 10:16 AM, V5 (LPN) stated that on 1/7/23, V5 was going down R1's hallway, passing medications. V5 stated that R1 was still in bed, so V5 stopped at R1's room, told R1 to open R1's eyes because breakfast was going to be coming soon. V5 stated V5 was "one door down" when V5 heard "terrible yelling and screaming" coming from R1's room. V5 stated that R1 was on the floor in R1's bathroom and R1 had been incontinent of urine. V5 denied that R1's call light was on and V5 stated R1 was "barefoot with no shoes or socks on." V5 stated that due to R1's history of a stroke, R1 is flaccid on R1's left side. V5 stated 911 was called and R1 was then sent to the hospital for evaluation.	S9999		

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S9999	Continued From page 12 R1's Health Status Note on 1/7/2023 at 9:55 AM documents that V5 was notified by the Emergency Department that R1 was being transferred to a different area hospital due to R1 having a fractured left hip and subdural bleeding. R1's Radiology Report on 1/7/23 documents "XR (X-Ray) Hip Two Views Unilateral Left Impression: Acute distracted avulsion fracture of greater trochanter. Acute impacted femoral neck fracture also suspected." R1's Radiology Report on 1/7/23 documents "CT (Computed Tomography) Chest Abdomen and Pelvis W (with) Contrast Impression: 1. Comminuted and mildly impacted fracture of the left femoral neck with extension into the greater trochanter with mild displacement of the greater trochanter fracture fragment. 3. Left hip soft tissue contusion." R1's Radiology Report on 1/7/23 documents "CT Head or Brain WO (without) Contrast Impression: 1. Large matched attenuation subdural hematoma overlying the right frontal, parietal and temporal convexities. High attenuation component is most consistent with more recent blood products." A repeated CT Head or Brain WO Contrast on 1/8/23 documents R1 with an acute on chronic right subdural hematoma. R1's Neurointerventional Surgery History and Physical, dated 1/10/23, states, "(R1) presented 1/7/23 from (R1's Skilled Nursing Facility) for evaluation following a fall. (R1) sustained a large subdural hematoma, left femoral neck fracture, and an avulsion fracture of the left greater trochanter. (R1) had reversal of Coumadin at the time of admission and subsequently a subdural drain placed on 1/8/23. Interventional Neurology	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006266	A. BUILDING: ______ B. WING ______	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 was consulted for MMA (Middle Meningeal Artery) Embolization. (R1) is also POD (post-operative day) one for ORIF (Open Reduction Internal Fixation) medullary implant (proximal femur)." (A)	S9999		