STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010250	A. BUILDING: _____ B. WING _____	C 04/17/2023

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SEMINARY MANOR	2345 NORTH SEMINARY STREET GALESBURG, IL 61401

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S 000	Initial Comments Facility Reported Incident investigation of 3/23/23 #IL00158663	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care 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 regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement fall interventions and complete neurological assessments following an unwitnessed fall for two of three residents (R1, R2) reviewed for falls in the sample of three. These failures resulted in R1 getting up from her wheelchair and sustaining a displaced fracture of greater trochanter of right femur, closed nondisplaced fracture of 7th cervical vertebral body, and transverse minimally displaced/impacted fracture of eight proximal humeral metaphysis. Findings include: The facility's Emergencies policy, dated 4/3/18, documents, "Falls: If a fall is unwitnessed, notify physician and initiate neuro checks." A blank facility Neuro Vital Signs for 72 hours form, no date available and provided by V2 Director of Nursing on 4/17/23, documents, "Every 15 minutes for one hour; Every 30 minutes for one hour, Every one hour for four hours, every	S9999		

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S9999	Continued From page 2 four hours for 24 hours, every shift for 72 hours." 1. R1's Event Report, dated 3/10/23 at 12:47 p.m., documents that R1 had a fall by scooting off of her wheelchair while in the day room participating in activities. The report has no documentation of immediate measures taken and/or interventions put into place following R1's fall. R1's Fall Care plan, dated 2/24/23, documents, "R1 at risk for falling related to recent illness/hospitalization and new environment. Last reviewed/revised: 3/3/23." This care plan has no revision following R1's fall on 3/10/23. R1's Event Report, dated 3/23/23 at 2:24 p.m., documents that R1 had an unwitnessed fall in her room, and "R1 was observed on the floor by (V5 Activity aide) and nurse was called. R1 was trying to get up by herself and walk. Nurse assessed R1. R1 did not have any wounds and did not complain of pain at this time. R1 was placed back in wheelchair per facility policy". The report has no documentation of immediate measures taken and/or interventions put into place following R1's fall. R1's current medical record has no documentation of neurological checks being completed following R1's unwitnessed fall that occurred at 2:24 p.m. On 4/13/23 at 12:10 p.m., V12 (CNA) stated, "For lunch, (R1) had a caregiver (V4 R1's Private caregiver) that came in to help her eat. She had finished up lunch and (V4) had just finished up and left. I saw (R1) up in her wheel chair and then I went to break. When I came back from break, I heard that she had fallen. I didn't know of her	S9999		

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having any dycem (non slip material) in her wheelchair, and they didn't ask me to put anything in her wheel chair."

On 4/13/23 at 12:17 p.m., V13 (CNA) stated, "I was in another resident's room. Then, when I came out, I walked by her room and she was on the floor. She could slip out of that chair like nothing. We got her up off of the floor with the mechanical lift and she was smiling. She never complained of anything. We got her up into the wheelchair and brought her out of her room. She should have already had the nonslip pad in her wheel chair, but honestly I don't know if it was there or not."

R1's Event Report, dated 3/23/23 at 5:15 p.m., documents, "Location of fall: Dining room. R1 was sitting in her wheelchair waiting for dinner to be served. R1 got up out of her wheelchair and was trying to move sign out of the way. Was fall witnessed: Yes-CNA (Certified Nursing Assistant) was in the dining area. Pain Assessment: Right hip and right arm severe horrible intense pain." The investigation also includes written staff interviews including: V8 (CNA)-"I was down on 400 hall getting resident ready to go for dinner when the fall took place. I was told by a coworker that (R1) fell. I told the nurse about it."; V7 CNA-"I was in the dining room when I noticed (R1) on the ground. I went to get (V6) and (V3 Licensed Practical Nurse-LPN) to let them know (R1) had fallen."; V6 (CNA)-"I was pushing a resident into dinner room when (V7) told me (R1) had fallen so I sat with (R1) while (V7) went and got nurse."

R1's Nurses' notes, dated 3/23/23 at 5:19 p.m., document, "Nurse calls 911 for ambulance to be sent over to hospital for further evaluation."

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R1's ED Provider notes, dated 3/23/23 at 7:49 p.m., document, "Chief Complaint: R1 presents with fall. R1 arrives from nursing home with (V11 R1's Power of Attorney) for complaints of two falls today. (V11) states she is usually in a wheelchair and thinks she can get up, but he states she is too weak to stand on her own. It is difficult to get any answers out of R1 due to her Alzheimer's. (V11) states she had originally complained of right hip pain. (V11) is unsure if this was witnessed or not. Clinical Impression: Displaced fracture of greater trochanter of right femur. Closed nondisplaced fracture of seventh cervical vertebra.

R1's Nurses' notes, dated 3/24/23 at 12:16 a.m. and signed by V9 (LPN), document, "R1 returned to facility via ambulance with diagnosis of displaced fracture of the greater trochanter of right femur, and closed non-displaced fracture of seventh cervical vertebra. PRN (as needed) order for Norco received. Cervical collar in place."

R1's current medical record has no documentation of neurological checks being completed upon R1's return from the hospital following her fall that included head involvement.

R1's Nurses' notes, dated 3/24/23 at 10:51 a.m. and signed by V10 (Registered Nurse-RN), document, "R1 was not swallowing this am, would not respond to any commands, unable to give pain medication for recent fractures. Due to condition, Physician notified and would like (R1) evaluated in the ED again. Ambulance called to transport resident."

R1's ED Provider Notes, dated 3/24/23 at 12:41 p.m., document, "Chief Complaint: R1 presents with Concussion altered since yesterday. R1 fell

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S9999	Continued From page 5 has increasingly weakness today's slow to respond. She fell and has a right hip fracture nondisplaced C7 fracture. Is increasingly weak today. Clinical Impression: General weakness. Falls Frequently. Humeral head fracture, right, closed." R1's Nurses' notes, dated 3/26/23 at 2:30 p.m., document, "R1 arrived to facility by stretcher. Transferred from hospital for recent falls with fractures to C7 vertebrae, right shoulder, and right trochanter. R1 will be admitted to hospice for comfort measures." The facility report to the State Agency, dated 3/27/23, documents, "(R1) observed lying on right side on floor in main dining area near doorway. R1 last noted siting up in wheelchair, at assisted feed dining table with wheelchair brakes locked. R1 wheelchair noted pushed back though remained positioned at dining table. R1 with report of increased discomfort to right hip and right arm. Sent to ED (Emergency Department) for further evaluation 3/23/23 and returned to facility with diagnosis as follows: 1) Displaced fracture of greater trochanter of right femur 2) Closed non-displaced fracture of 7th cervical vertebral body. R1 returned to hospital ED 3/24/23 for noted change in condition with request for further follow-up. R1 admitted to hospital at that time for diagnosis as follows: Weakness, Falls with injury: 1) Displaced fracture of greater trochanter of right femur 2) Closed non-displaced fracture of 7th cervical vertebral body 3) Transverse minimally displaced/impacted fracture of eight proximal humeral metaphysis with no dislocation." R1's Fall care plan, dated 3/26/23, documents that R1's previous fall care plan was discontinued	S9999		

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S9999	Continued From page 6 on 3/27/23, and the care plan was revised to include R1's fall interventions related to all three of R1's on 3/26/23. On 4/13/23 at 11:00 a.m., V3, stated, "(R1's) first fall on that day (3/23/23) was in her room. She was really antsy in her room. I don't know what she was trying to do that day. Afterwards she was agitated, so we brought her out to the nurses' station. She didn't hurt anything with that first fall. With her 2nd fall, residents were still getting wheeled into the dining room when it happened. The meal had not started. (V6) told me (R1) had got up out of her chair to move a wet floor sign. She turned to pick up the sign and fell on her right side. (V6) is who I thought witnessed the fall. (V8) came and got me letting me know that (R1) had fell. When I went in to initially assess her. She was laying on her right side. I asked her if she was in pain and she said her right side was hurting. I told them not to move her and I immediately called 911." On 4/13/23 at 2:35 p.m., V6 stated, "I never witnessed (R1) fall. I was pushing another resident into the dining room and (V7) came and got me and said (R1) was on the floor. I didn't see her fall. I went over and sat with (R1). I didn't touch her because I can't do that. She said her arm and her hip both hurt. She complained the most of her arm and she was laying on it. When we start putting residents into the dining room, the Activity Aide is supposed to be in there to supervise the residents for this purpose. I didn't see an Activity Aide anywhere. When I got to work that day, I got report that (R1) had fallen, but I wasn't told anything to do different with (R1). I don't even know who took (R1) to the dining room, but I know her wheelchair was up to the table and the wheels were locked. I don't know	S9999		

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how she got out of that wheel chair she would have had to climb over it somehow or something. I honestly do not remember her having any type of dycem in her wheelchair."

On 4/17/23 at 10:10 a.m. V8 stated, "I did not witness (R1) fall. I was helping a resident in the bathroom when (V7) came and told me that (R1) had fallen in the dining room. I went to (V3) and told her that (R1) was on the floor. After telling (V3), I went to sit with (R1). She was sad laying there on her right side in lots of pain. The last time I had saw (R1) she was sitting by the nurses' station. I'm not sure who even took her to the dining room. Staff are bringing residents into the dining room, but no one was directly supervising that assisted dining room. No one stayed with the residents. When I came onto shift, no one told me that (R1) had fallen earlier in the day. I didn't know until V6 told me when we were sitting with (R1). Her wheelchair was pushed up to the table locked, and there was nothing in the wheelchair. There wasn't any cushion or any of that sticky stuff."

On 4/17/23 at 2:30 p.m., V5 (Activity Aide) stated, "Prior to (R1's) incident (3/23/23) my responsibility during meal times was to push residents to the meal, help serve trays, and then help residents back to their rooms. We were not responsible for staying with the residents to make sure they were supervised. I pushed (R1) down to the dining room, but no one told me she couldn't be left unattended. On our way to the dining room, a CNA stopped me and said to make sure I pushed (R1) up to the table and locked her wheels that was it. So that is what I did. Then, I left to help other residents. I did not witness (R1) fall. Her wheel chair was still at the table but turned out a little ways after she fell."

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On 4/17/23 at 9:30 a.m., V9 (LPN) stated, "When (R1) came back from the hospital and was transferred to the bed, she said 'oh' when they moved her arm and that was it. I pulled Norco from our back up box to give to her and by the time I got back down there she was asleep. So, I didn't wake her. She slept the rest of my shift. Normally, if a resident has an unwitnessed fall we start neurological checks, but since she went to the hospital, I didn't start any when she came back. I didn't get anything in report of what we should do different to prevent her from falling again when she came back from the hospital. She was fine until (V10) got here that morning, and (V10) sent her out to the hospital."

On 4/13/23 at 2:45 p.m., V10 stated, "I came in the morning after she returned and immediately went down at 6 am to assess her. I couldn't believe they sent her back because she was not doing well. She was out of it and couldn't even swallow to take her pain medication. When (V2) got here I got her opinion and sent her back out to the ED. We normally have a neurological check sheet for the checks but we didn't have one when I got here that morning. I just assessed her on my own."

On 4/17/23 at 10:20 a.m., V2 (Director of Nursing) stated, "After the first couple days of being in the facility, (R1) started trying to get up out of the wheelchair independently. The fall on 3/10/23 she was in activities in the day room scooting around and slid to the floor. It was witnessed. At that time, we initiated dycem to her wheel chair seat. It should have been in her wheelchair after that fall. I can't find it on the careplan. On 3/23/23, (R1's) first fall was she attempted to stand up from wheelchair and fell. It

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was an unwitnessed fall. I do not have any observations (documentation) of neurological checks being documented after the initial fall vitals. Neurological checks should be started when a fall is unwitnessed. The frequency is according to the neuro vital signs sheet. The intervention for this fall was to assist to common areas while in wheelchair to be supervised. The nurse is also responsible for reporting the new intervention to the staff. Later in the day, she was in the door way of the assisted dining room area lying on her right side. There was no one who actually witnessed the fall. The event report is not correct by saying the fall was witnessed. Activities has someone who stays in the dining room while residents are brought in. There was educational needs with the activity staff because they didn't stay in the dining room to supervise the residents. They were actually assisting in transporting residents to the dining room. The intervention was to be in a supervised area. The intervention after this fall was to not leave unattended while up in wheelchair. There was no documentation of any type of neurological assessment when she returned from the hospital after the 2nd fall on 3/23/23 because again there is no event in the computer where they would have documented it. (V10) obviously did a neurological check when she came on shift because she noticed a change in her mental status and sent her to the ED." V2 confirmed that all of the new fall interventions were not on R1's care plan until 3/26/23.

2. On 4/13/23 at 11:53 am, R2 was pleasantly confused sitting at the dining room table feeding herself with her wheeled walker at her side.

R2's Fall Event form, dated 1/2/23 at 12:50 p.m., documents that R2 had a fall in her bathroom resulting in a laceration to her left temple.

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S9999	Continued From page 10 R2's Nurse's notes, dated 1/2/23 at 12:41 p.m., document, "CNA notified nurse that R2 was on the floor in restroom near the toilet. Upon entering restroom, R2 was in a supine position with her head against the door. When asked what happened R2 stated 'I have to use the bathroom.' 2 cm (centimeters) laceration to left forehead." R2's current medical record has no documentation of neurological checks being completed following R2's fall with head involvement. On 4/17/23 at 10:20 a.m., V2 (Director of Nursing) confirmed that neurological checks were not done on R2 following her fall on 1/2/23. (A)	S9999		