STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011381	A. BUILDING: _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE MORRIS	1095 TWILIGHT DRIVE MORRIS, IL 60450

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S 000	Initial Comments Complaint Investigation 2373884/IL159705	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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. These requirements are not met as evidenced by: Based on observations, interviews and record reviews the facility failed to implement interventions to prevent a resident's fall. This failure resulted in R1 sustaining a bilateral subdural hematoma (brain bleed). This applies to 1 of 3 residents (R1) reviewed for falls. Findings include: R1's electronic health record showed that on May 4th, 2023, at 2:36 pm, R1 was observed on the floor with his wheelchair under him. R1's face sheet showed R1 was readmitted on May 9th, 2023, 5 days later. R1's May 4th, 2023, hospital CT scan of his head showed new bilateral subdural hematomas ... The left subdural hematoma spans the entire left cerebral hemisphere. ...The right subdural hematoma extends along the right frontal and parietal lobes ... There is approximately 5 millimeters of left to right midline shift at the level of the lateral ventricles.	S9999		

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S9999	Continued From page 2	S9999		

On April 4th, 2023, at 12:45pm, R1's progress notes showed R1 had a fall while he was in his wheelchair.

On May 12th, 2023, at 2:41pm V2 (Director of Nursing) said that on May 4th, 2023, R1 had an anti-rollback device on his wheelchair, and V2 had determined that it was the root cause for his fall. V2 said that she made this determination after evaluating R1's wheelchair and deemed the anti-rollback device was not working properly. V2 said she also determined the anti-rollback device was the cause when she was told by V8 that R1 has a history of pushing himself backwards while in his wheelchair. V2 said that on May 9th, 2023, she took R1's wheelchair to maintenance and had maintenance removed the anti-rollback device and threw it away. V2 said that on April 4th, 2023, R1's anti-rollback device did not work properly, "The same thing happened on April 4th, 2023." R1's April 5th, 2023, progress note showed that the IDT (Individual Treatment Team) reviewed R1's April 4th, 2023, fall and put an intervention in place to place a (rubber no-slip) cushion in R1's wheelchair. On May 17th, 2023, at 3:15pm, V2 said that she did not think that the facility had inspected R1's wheelchair and "I feel strongly that if the wheelchair had been inspected according to the manufacturer's directions it would have prevented R1's wheelchair from tipping over on May 4th, 2023." V2 said that she doesn't know when the anti-rollback device was put on R1's wheelchair, or who put it on R1's wheelchair.

On May 12th, 2023, at 3:07pm V6 (Certified Nurse's Assistant) said that R1 has a history of pushing himself forwards and backwards while he is in his wheelchair and that R1 likes to move a

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S9999	Continued From page 3 lot. On May 12th, 2023, at 3:21pm V7 (Occupational Therapist) said that on April 4th, 2023, she saw R1 sitting in the dining room, and R1 pushed back from the table and his wheelchair "popped a wheelie". V7 said then R1 leaned forward and started to fall out of his chair. V7 said "I don't recall the brakes being on." V7 said that R1 had a history of pushing himself backwards while he was in his wheelchair. On May 12th, 2023, at 3:41pm V1 (Administrator) said that he saw camera footage from R1's fall on May 4th, 2023, and he saw that R1 fell backwards in his wheelchair to the floor hitting his head. V1 said that the footage showed R1 reaching behind himself, pulling on the rail to pull his wheelchair backwards. V1 said when R1's wheelchair tipped backwards, R1 was still in the chair when his body hit the floor. V1 said that the facility's legal department does not allow him to show the footage to anyone. On May 17th, 2023, at 9:00am V1 was asked if he could view the footage again and tell the surveyor what he is viewing and V1 said that the facility no longer has the footage, it is erased after 7 days. On May 17th, 2023, at 9:21am, V8 (Nurse) said that R1 has a history of pushing himself forward and backwards while in his wheelchair, and there was an anti-rollback device on R1's chair on May 4th, 2023. On May 17th, 2023, at 12:03pm, V8 said that on May 4th, 2023, R1 was observed on the floor, "his wheelchair had fallen backwards, ... his buttocks were still in the wheelchair." V8 said R1's wheelchair was not pressed or caught on the wall or corner of the wall. V8's May 5th, 2023,	S9999		

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witness statement showed that R1 moves around and adjusts himself a lot while he is in his wheelchair.

On May 17th, 2023, at 10:01am V9 (Certified Nurse's Assistant) said that he "works with R1 every day and sometimes the wheels on his wheelchair are locked and R1 will rock his wheelchair back and forth really fast ... When this happens R1's front wheels will raise up off the ground really fast also." V9 said that when R1's wheelchair is unlocked he will try to propel his wheelchair forward and backwards as much as he can.

On May 17th, 2023, at 12:15pm, V12 (R1's Primary Care Physician) said that on May 4th, 2023, R1 had a fall, and it caused bilateral subdural hematomas. V12 said that prior to May 4th, 2023, R1 had no signs or symptoms of any active bleeding in his brain and no neurological compromise.

On May 17th, 2023, at 1:37pm, V4 (Director of Rehab) said that if the anti-rollback devices are installed improperly, it can cause the wheels on the wheelchair to lock and the wheelchair to tip back. V4 said that she has seen this happen on residents' wheelchairs while they were using them, and she has sent the wheelchair to maintenance to be fixed.

On May 17th, 2023, at 2:00pm V13 (Environmental Service Director) said that the facility is to inspect every wheelchair every quarter and he has no knowledge or record of any wheelchair inspections being done in 2023. V13 could only provide wheelchair inspection documentation for 2022.

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S9999	Continued From page 5 R1's care plan with initiated date of April 5th, 2023, and revision date of April 12th, 2023, showed an intervention on May 9th, 2023, to remove the anti-rollback device from R1's wheelchair. R1's care plan did not show any interventions to use anti-rollback devices. The facility's instructions for wheelchair inspections shows that anti rollback brakes are to be checked for operation and adjustments for manufacturers specs. The facility's Wheelchair Inspection log only shows inspections for the year 2022. The facility's Fall Prevention Program with revised date of 05/2022, showed the program will include measures to determine the individuals needs of each resident by assessing the risk of falls and implementations of appropriate interventions to provide necessary supervision and assistive devices as necessary. (A)	S9999		