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
	IL6003768	A. BUILDING: ____ B. WING ____	C 04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF MASCOUTAH	901 NORTH TENTH STREET MASCOUTAH, IL 62258

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S 000	Initial Comments FRI of 4/11/2023/IL159054	S 000		
S9999	Final Observations Statement of Licensure 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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	**Attachment A** **Statement of Licensure Violations**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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, record review and observation the facility failed to implement fall safety measures for one of three residents, (R3) reviewed for falls in the sample of 8. This failure resulted in R3 falling and fracturing the distal end of her clavicle.

Findings Include:

R3's Minimum Data Set, (MDS), dated 3/23/23 documents R3 is an extensive assist of two staff members for transfers and bed mobility. R3's MDS also documents, for balance moving on and off the toilet and moving from seated to standing is not steady only able to stabilize with staff assistance. R3 is moderately cognitively impaired.

R3's Transferring Care Plan dated 3/10/23 documents (R3) "has a self-care deficit in

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transferring r/t, (related to), hemiplegia secondary to past CVA, (Cerebrovascular Accident). She requires extensive assist to complete tasks currently. 1. Explain procedure. 2. Lock wheelchair brakes. 3. Apply gait belt. 4. Instruct and assist to standing position using extensive assist and gait belt. 5. Instruct and assist to pivot and sidestep towards the front of the chair. 6. Instruct and assist to slowly sit down in w/c, (wheelchair). 8. Praise all efforts. 9. Provide encouragement during transfer if becomes fearful. 10. Attempt transferring using limited assist x, (times), 1, three times per week, provide more assist if unable. Fall Care plan dated 3/10/23 documents (R3) slid out of her wheelchair on 3/9/23 and a note was added to her wheelchair as well as educate the resident to call for help. The fall care plan dated 3/10/23. The fall of 4/11/23 documents the intervention: is staff educated to not leave (R3) unattended in the bathroom."

R3's Fall Risk Evaluation dated 4/12/23 documents R3 is a high risk for falls.

R3's Nurses Note dated 4/11/23 documents, resident fell in her bathroom and hit her head. (R3) was lying on her left side. No c/o, (complaint of), pain or discomfort. Resident refused to go to the hospital. POA, (power of attorney), made aware and said, if vitals are stable, it was okay for the resident to stay in the facility and not go to the hospital as the doctor requested.

R3's Nurses Note dated 4/12/23 documents, (R3) is complaining of pain to her left shoulder, (R3) fell yesterday in her bathroom and has refused to go to the hospital to get checked out. Request was made to (V17), Nurse Practitioner, (NP), for X-ray, (V17) ordered resident be sent to ER,

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(emergency room), resident continues to refuse to go to ER. Educated (R3) on importance of getting checked out, prn, (whenever necessary), pain medication given.

R3's Nurses Note dated 4/12/23 at 6:32PM documents, order received for X-ray of left shoulder faxed.

R3's Nurses Note dated 4/12/23 at 9:32PM documents, technician completed X-ray of residents left shoulder and clavicle.

R3's Nurses Note dated 4/12/23 at 10:30PM documents, comminuted FX, (fracture), of distal end of clavicle. Nurse contacted (V6), Primary Care Physician, new order for referral to ortho, (orthopedics).

R3's Nurses Note dated 4/14/23 documents, (V18), daughter, of R3 spoke with this writer and she has arranged an ortho appointment for (R3) at (local) Orthopedics and Sports medicine for Friday, April 21st at 9am. Transportation is arranged through residents' insurance. Resident made aware of upcoming appointment. Plan of care continues.

R3's Nurses Note dated 4/21/23 documents, Ortho appointment for resident has been rescheduled for Tuesday May 2nd at 1:30PM. Arrangements for transportation will be made. (V18), daughter/POA, made aware.

On 4/25/23 at 2:40PM V7, Social Service Assistant/Transportation, stated, "they went to the wrong address to pick her up for her appointment. They had the wrong address on file. Even though I gave them the correct address."

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On 4/26/23 at 10:40AM V13 and V14, (CNAs), Certified Nursing Assistants, entered the room and asked R3, if they could toilet her. V14 placed a gait belt around R3's waist and rolled her into the bathroom. V13 and V14 locked her chair. R3 stated, I'm scared I don't want to fall again, they let me fall. V13 and V14 lifted her up out of her chair with the gait belt and asked her to pivot to the toilet. Once lined up with the toilet they removed her BM, (bowel Movement), soiled incontinence brief and sat R3 on the toilet, where she urinated. Incontinence care was provided with no issues, and R3 was transferred back to her wheelchair.

R3's Initial/Final Report dated 4/11/23 documents reported by nurse on duty, (R3), was being toileted and attempted to reposition self on toilet and fell. Final Report documents, slightly comminuted fracture of Distal end of the Left Clavicle. The Final Report also documents, (V10), stated, she was in the room outside of the bathroom completing a task for the resident's roommate. V12 stated, that she placed the resident, (R3), in the bathroom and began to complete another task in bedroom right outside the bathroom. They both stated, they heard a noise and noted the resident, (R3), laying on her left side near the toilet. Intervention of educating staff to not leave resident unattended in bathroom.

On 4/26/23 at 9:39AM, V10, CNA, stated, "I went in there with the other CNA, (V12), sat her on the toilet. The bathroom in her bedroom, the door to the bathroom was open. I was making her bed, and (V12), was making the other resident's bed and (R3) fell off the toilet. (V12) ran to get the nurse, and I stayed with (R3). (R3) was yelling I'm not going to the hospital."

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On 4/26/23 at 9:43AM, V11, Licensed Practical Nurse, (LPN), stated, "They call me down there, because she, (R3), was on the floor, on her left side. We started Neuro checks, and V6, Primary Care Physician, wanted her, (R3), to go out to the hospital, but she refused. She wanted to go smoke. They will not let her smoke in the hospital. There was no complaint of pain all night and the next day. She complained after I went home."

On 4/26/23 at 1:35PM V12 stated, "I was the one who actually put her on the toilet. I take her to the bathroom in her room. (V10) came with me, we sat her on the toilet. Her wheelchair was right there in the doorway I was going to make her bed. I turned to see her leaning, but she had already hit the ground."

On 4/27/23 at 10:55AM, V17 stated, "No she should not have been left in the bathroom alone."

The facility policy Fall Prevention and Management dated 7/2022 documents "this facility is committed to maximizing each resident's physical, mental, and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. All incidents and accidents with serious physical injury will be reported to IDPH, (Illinois Department of Public Health), within 24 hours. A full written investigate report is required by IDPH within 5 days of the incident.

(B)