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
	IL6000756	A. BUILDING: ______ B. WING ______	C 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE HEALTH & REHAB CTR, THE	873 GROVE STREET JACKSONVILLE, IL 62650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Survey: 2348905/IL165912	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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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 provide supervision and assistance, do a thorough fall investigation including a root cause analysis, and implement progressive intervention to prevent falls for 3 of 4 residents (R1, R4, R5) reviewed for falls. This failure resulted in R4 falling and sustaining a left sided subdural hematoma, subarachnoid hemorrhage with intraventricular hemorrhage which was the cause her death.

Findings include:

1. R4's Electronic Admission Profile documents that R4 was admitted on 9/21/21 and has diagnoses of Traumatic Subarachnoid Hemorrhage without loss of consciousness 9/1/23 and Palliative Care on 9/5/23 with previous diagnoses of Chronic Obstructive Pulmonary Disease, Heart Failure and Atrial Fibrillation.

R4's Minimum Data Set (MDS), dated 6/14/23, documents that R4 is severely cognitively impaired and required supervision and physical

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assistance of 1 staff member for bed mobility, transfers, walking in the room and on the corridor, locomotion on the unit, dressings, toileting, and personal hygiene. This MDS also documents that during transition and walking R4 is not steady but is able to stabilize self without staff assistance.

R4's Fall Scale, dated 6/14/23, documents that R4 is a high fall risk.

R4's Care Plan, documents, "Focus: Date Initiated: 9/30/2021. Revised 9/15/23. FALL RISK: (R4) is at risk for falls due to advanced age, unsteady at times, weakness, COPD (Chronic Obstructive Pulmonary Disease) may cause shortness of breath. She is very hard of hearing and may need questions/information written down for her to understand. 8/29/23 sustained a left side subdural subarachnoid and intraventricular hemorrhage. Date Initiated: 3/26/23. Goal: Minimize risk of falls / injury through the review date. Interventions: Date initiated: 8/24/23. Therapy to evaluate; assess footwear; notify MD for SpO2. Date initiated: 1/20/22. Allow rest breaks as needed to minimize shortness of breath, place head of bed up to minimize shortness of breath lying flat. Date Initiated: 1/20/22 Call light with reach while in bed and at bedside. Keep pathway clear."

R4's Care Plan, initiated 11/16/21, documents "ADL (Activity of Daily Living) Self care Performance Deficit r/t (related to) Impaired balance, diagnosis of CHF (congestive Heart Failure) & COPD (Chronic Obstructive Pulmonary Disease), which can impact level of ADL abilities. Goal: Sate Initiated 11/16/21. Maintain Current level of function through the review date. dressing: Will perform upper body dressing, putting arms in sleeve and pulling garment over

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S9999	Continued From page 3 head by next review. Interventions: Date Initiated: 1/19/23. Bathing 1 assist. Dressing: Supervision. Toileting: Supervision. Bed Mobility: Supervision." R4's Care Plan, initiated on 3/26/23, documents, "INCONTINENCE RISK: (R4) is occasionally incontinent of bowel/bladder, needs staff assist at times with toileting. Goal: Date Initiated: 3/26/2023. Minimize risks of incontinence through the review date. Interventions: Date Initiated: 3/26/2023. Encourage and assist to toilet routinely and provide peri-care when incontinent." R4's Activity of Daily Living (ADL) Plan of Care flow sheet, dated 8/16/23 - 8/22/23, documents that R4 was observed walking in her room 20 times, 11 times she was independent, 3 times she needed supervision and 6 times she needed one staff member physical assistance, 13 times toileting, 4 times she needed supervision, 7 times she need physical help from 1 staff member, 1 time she needed limited assistance from 1 staff member and 1 time she was independent. On 8/22/23 R4 was totally dependent on one staff member for toileting. R4's Health Status Note, dated 8/23/2023 at 2:30 PM, documents, "Note Text: CNA (Certified Nurse Aide) came out of another room found resident sitting on buttocks in front of B/R (bathroom) door was closed walker at residents feet resident lying partially on floor, when staff asked her what happened stated "i got dizzy and lost my balance" resident assessed resident c/o (complaint of) pain unable to lay back on floor resident started yelling out in pain, unable to do AROM (active range of motion) c/o pain in right hip and leg, no other injuries noted . CNA and Administrator with resident for duration of time."	S9999		

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S9999	Continued From page 4 R4's Health Status Note, dated 8/23/2023 3:05 PM, documents, "Note Text: Ambulance here. resident transported to hospital at this time." R4's Health Status Note, dated 8/23/2023 10:30 PM, documents, "Note Text: Resident returned to facility with facility driver from ER (Emergency Room), new order received for Oxygen at 2 liters per NC (nasal canula). Resident is refusing to wear the oxygen, she absolutely refuses. resident educated on the need for the oxygen, but she will not put it on. Call light is in reach, will continue to monitor." R4's Local Hospital Emergency Room Report, dated 8/23/23, documents, "Rational: This is a 98-year-old African American female who presents per EMS (Emergency Medical Services) to the ED (Emergency Department) for evaluation. Patient is extremely hard of hearing, and it is more successful to write notes. Patient is alert oriented x 2. This is her baseline. History is given that she was up walking to the bathroom became dizzy and fell. She reports that she fell onto her right hip. She denies any loss of consciousness. She denies striking her head. She denies neck or back pain. Patient denies any chest pain or increasing shortness of breath. Reports right hip pain. CT (Computed Tomography Scan) head and neck negative for bleed or fracture." It continues, "Patient reports shortness of breath when she is up to the bathroom with assistance. Pulse ox (oxygen) will dropped down into the 80s. 2 L (liters) of oxygen applied. Plan is to return patient to the nursing home with oxygen. Discharge Information: Oxygen at 2 liters per nc (nasal canula) especially during activity." The Facility Incident Report, dated 8/23/23,	S9999		

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documents, "Resident is independent was found sitting in front of her bathroom door sitting on buttocks with feet extended in front of her walker at her feet by a CNA, assessment was done resident c/o of buttocks per writing board and resident stated she was coming out of the bathroom and got dizzy and lost her balance. Immediate Action Taken: Assessment done vitals obtained SPo2 (oxygen saturation) 92 RA (room air) P (pulse) 76 R (respirations) 20 temp (temperature) 98.1 B/P (blood pressure) 114/40 staff started to have resident lay down to put full body lift under her when she yelled out "oh my hip" resident left on floor with staff at side monitoring. Notes: Fall risk meeting completed. Continue to encourage O2 (oxygen) compliance, notified (V19 Physician) of resident non - compliance with N.O (new order) for O2, re-evaluate resident transfer, assess appropriate footwear."

R4's Care Plan Intervention, initiation date of 8/24/23, documented "Therapy to evaluate; assess footwear; notify MD (medical doctor) for SpO2."

R4's ADL Plan of Care flow sheet, dated 8/22/23 - 8/28/23, documents that R4 was observed walking in her room 14 times, 1 time she was independent, 6 times she needed supervision and 7 times she needed one staff member physical assistance, 20 times toileting, 4 times she needed supervision, 7 times she need physical help from 1 staff member and 8 times she was independent. On 8/22/23 R4 was totally dependent on one staff member for toileting.

The Facility Fall Interventions Sheet, dated August 2023, documents, "8/23/23 (R4) Intervention: Re eval (re-evaluate) transfer,

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assess app (appropriate) footwear, notify MD (medical doctor) regarding need for O2."

R4's Health Status Note, dated 8/24/2023 10:58 AM, documents, "Note Text: Resident O2 sat reading 78% on RA this morning due to resident refusing to wear O2, writer notified poa (Power of Attorney) by phone to see if able to encourage resident to wear O2 but was unsuccessful. (V19, Physician) faxed info, will continue to monitor."

R4's Health Status Note, dated 8/24/2023 9:49 PM, documents, "Note Text: continues to have low SPO2 below 80%, refuses to allow O2 to be applied, continues to refuse assistance to toilet, remains up in recliner and getting up without assistance, as not complained of pain, refused lung assessment."

R4's Health Status Note, dated 8/26/2023 1:38 AM, documents, "Note Text: Resident continues to refuse O2 at this time. Resting in recliner at this time watching tv with no distress noted. Will not allow pulse ox (oxygen saturation) to be read 'I don't need that. No. No thank you.'"

R4's August 2023 Physician Orders documents, "Order Date 8/28/23 7:42 AM. PT/ OT (Physical Therapy / Occupational Therapy) to eval (evaluate) and treat as indicated."

R4's PT (Physical Therapy) Evaluation & Plan of Treatment, dated 8/28/23, documents that R4 had a prior level of functioning of independent for Sit to lying, Sit to stand, Chair/bed to chair transfer, toilet transfer, ambulating safely with a 2 wheeled walker and on 8/28/23 R4 required Partial to moderate assistance with these tasks except for Sit to lying which R4 required Supervision or touching assistance.

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S9999	Continued From page 7 R4's PT Evaluation & Plan of Treatment, dated 8/28/23, documents, "Reason for Referral / Current Illness: Moderate Complexity Evaluation: Pt (Patient) is a 98 y/o female who was referred to PT for strengthening, balance and functional training following a fall on 08/23. Pt cannot recall the circumstances of the fall but stated that the (R) (right) knee is bothering her. Medical Factors: Precautions: Falls, Pain on (R) knee. Reason for therapy: Patient presents with balance deficits, strength impairments, safety awareness deficits, proximal instability, postural alignment / control and gross motor coordination deficits and in consideration of history, personal factors, and functional limitations documented in the eval summary, patient requires skilled PT services to minimize falls, increase LE ROM (lower extremity range of motion) and strength, increase functional activity tolerance, facilitate motor control and facilitate independence with all functional mobility." R4's Restorative Note, dated 8/28/23 at 5:56 PM, documents, "Per Therapy recommendation, transfer status changed to one assist with walker, and walking program initiated at this time." On 10/31/23 at 8:23 AM, V12, Physical Therapist stated, "I evaluated her (R4) in the morning right before she fell (8/28/23). She was weak, having pain in her right knee and slightly confused. I think the fall on the 23rd was a result of these factors. She was needing help with transfers and ambulation." V12 was questioned if nursing staff could tell that R4 needed help with ambulation, V12 stated, "It was obvious that she needed help. She had a hard time standing from her recliner, turning, and walking to the bathroom. She needed minimal assistance. She was limping at	S9999		

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this time because of the right knee. I think I even worked with her to put more weight on her arms to take pressure off the knee while using the walker. I think I saw her not even an hour before her fall. She was sitting in her recliner when I left her. I did not speak to the nurse about my therapy evaluation that I had done. I don't know why it was 5 days after her first fall for my evaluation. I don't know if it was a weekend or when they got the order from the doctor for a therapy evaluation."

There was no documentation in R4's Medical Record documenting that V12 talked to any nursing staff regarding R4 requiring assistance with transfers and ambulation.

R4's Health Status Note, dated 8/28/2023 10:43AM, documents "Note Text: CNA went to resident room during fire alarm to close doors went across hallway to close their door when she was closing other door heard a thump went to check on resident CNA yelled another CNA and writer because unable to get resident door open but was able to see resident lying on floor but unable to get between doors writer ran to check resident unable to get doors open noted bathroom door pushing against outer room door staff unable to get between doors, 911 called immediately by maintenance for assistance. staff continue to try different staff members to get between doors, 1 CNA was able to get between doors and reposition resident so other staff ADON (Assistant Director of Nurses) and another CNA was able to get in and help and assess resident, resident noted to be laying on abdomen face down with blood noted on floor vitals obtained B/P (blood pressure) 104/92 P(pulse) 77 R (respirations) 24 T (temperatures 97.7 SPO2 78 ROOM AIR resident started on O2 at 5L per n/c

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at this time."

R4's Health Status Note, dated 8/28/2023 11:00, documents, "Note Text: Ambulance here resident out of facility at this time resident is alert with O2 on SPO2 now 95%.

R4's Health Status Note, dated 8/28/2023 2:21 PM, documents, "Note Text: Writer called (local) ER to check if any updates post fall 3 brain bleeds, being transfers to (Regional Hospital), can't see, confused."

R4's Regional Hospital Report, dated 8/28/23, documents, "Impression Plan, dated 8/29/23, (R4) is a 98-year-old female with PMH (Primary Medical History) atrial fibrillation / flutter not on AC (anticoagulants), aortic stenosis, HTN (hypertension), COPD (Chronic Obstructive Pulmonary Disease) who presents as trauma transfer from (Local Hospital) after sustaining an unwitnessed fall at her nursing home, sustaining subdural, subarachnoid, and intraventricular hemorrhages. Patient admitted to Hospital NCC (Neurological Critical Care). Active Problems: 1. Left sided subdural hematoma, subarachnoid hemorrhage with intraventricular hemorrhage, traumatic."

R4's Fall Investigation, dated 8/28/23, documents, "Mobility: Ambulatory with assistance. Mental Status: Oriented to Person Oriented to Place. Predisposing Physiological Factors: Gait imbalance. Impaired Memory. Other Info (information) Independent with transfers."

R4's Health Status Note, dated 9/1/2023 4:47 PM , Health Status Note, documents, "Note Text: Resident was admitted to the facility via facility transport. She was admitted into room (room # of

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S9999	Continued From page 10 R4). She was accompanied by family. She arrived in a wheelchair with (mechanical lift) sling under her. Resident was assisted into bed via (mechanical lift) lift. She has her helmet in place. Skin assessment done. Resident has a bruise to her right eye that measures 10x10xutd (unable to be determined). She has a small skin tear to her right cheek that is cover by steri strips. No other skin issue noted. Resident has a fall mat in her room. Resident is with family at this time." R4's Health Status Note, dated 9/2/2023 11:18 AM, documents, "Note Text: Resident sent to ER this morning per POA wishes due to resident O2 sat reading 83% with 3L of O2 N/C (nasal cannula), (local) ambulance called, transported resident to (local hospital) around 10:00 am." R4's (Local Hospital) Patient Insurance and Demographics, dated 9/2/23, documents, "Contrast induced nephropathy with acute kidney injury, acute liver injury, dehydration, lactic acido [sic]." R4's (Local Hospital) History and Physical, dated 9/2/23, documents, "In the ED, she was afebrile with stable blood pressures with no SBP (systolic blood pressure) greater than 100. HR was in the 40's with RR (respiration rate) up to 20. BUN/ Cr (blood urea nitrogen/ creatine) were elevated to 44/3.32 from baseline of 29/1.4 on 8/29 at (Regional Hospital). (V20, Hospital Doctor) discussed with POA, (Power of Attorney, V21), again at 7 pm regarding and she stated the family has discussed the situation and requested comfort measures with no hemodialysis. Per his note, 'She will be admitted to the floor with comfort measures.'" R4's Health Status Note, dated 9/5/2023 12:30	S9999		

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PM, documents, "Note Text: Resident returned to facility per ambulance."

R4's Health Status Note, dated 9/5/2023 4:17 PM, documents, "Note Text: Hospice nurse here today interviewed resident obtain new orders family at bedside updated on medication."

R4's Hospice Note, dated 9/14/2023 16:06, documents, "Note Text: Writer was notified by other floor nurse that the resident has expired. Writer and other floor nurse verified and called TOD (time of death) at 4:06 PM.

R4's Death Certificate documents R4's Date of Death: 9/14/23. Cause of Death: 1. Intraventricular Hemorrhage 2. Fall.
On 10/26/23 at 2:42 PM V3, Certified Nurse's Aide (CNA), stated, "She (R4) was on the 100-hall. I was actually working on the 200 Hall that day (8/28/23) and someone came and got me. I don't remember who. Her (R4's) room door was closed, and her bathroom door was open so when she fell, she was blocking the entry to the room. You could not open the door all the way. I squeezed through. Her head was lying on the left side of the door and her legs were facing into the room. I pulled her back a bit so the door could be opened and then I saw the blood. She was independent with her walker. She was alert not confused."

On 10/26/23 at 3:00 PM, V4 LPN (Licensed Practical Nurse), stated, "I wasn't here when she (R4) fell. She was independent. She would take herself to the bathroom. She used a walker. She ate in her room. She was alert and orientated times three. She was not a big talker. She would piddle around her room. She always sat in her recliner. She slept in her bed. She would dress

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herself and take herself to the bathroom. After the big fall when she came back, she was completely different. Her eyes where open but she was not there. She was a (full mechanical lift) complete and total care after that fall."

On 10/26/23 at 3:05 PM, V5 CNA, stated, "Before her (R4) big fall she was very quiet, always smiling. I helped her a few times. I would walk in her room to check on her and she would be taking herself to the bathroom so I would watch her and make sure she was ok and help her if she needed. She walked with a walker. She was alert and orientated times 2."

On 10/26/23 at 3:15 PM, V7, CNA stated, "Before the fall (8/28/23) she (R4) would get up by herself. She didn't ask for help or let you help her. She was safe to transfer herself with a walker. She would stay in her room."

On 10/30/23 at 1:05 PM, V8, CNA stated, "She (R4) was up and mobile. She would do things on her own. She didn't like for people to assist her. I would toilet her at meal times. She would wear her oxygen. She didn't have a problem with the long oxygen tubing. I was not here the day she had the bad fall. When she came back from that she was totally different. She was totally dependent on staff. She was non responsive, and she wouldn't use her communication board anymore."

On 10/30/23 at 2:23 PM, V9, LPN stated, "I work the night shift. (R4) was independent. She slept in her recliner. She took all her meals in her room. She walked with a walker. She didn't like help. She could use her call light. For me all she ever wanted was Laxatives. She didn't have any night time medications. When she came back from the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 hospital (8/23/23) she had oxygen, but she would always take it off. I would put it on her and then she would take it back off. I did SpO2 (oxygen saturation) checks on her. She would let you do that. I usually would check her once a shift. She was pretty alert. She could hold a conversation with you." On 10/30/23 at 3:12 PM, V11, LPN stated, "Before (R4) fell on 8/23/23 she took care of herself. She took herself to the bathroom. When she came back from the ER (Emergency Room) she did have an order for oxygen. The ER told me "good luck with it she won't keep it on." She refused to keep it on. We would go in and try to get her to wear it, but she wouldn't. I did let the doctor know via fax and I spoke with (V10 Nurse Practitioner) about it. I checked her pulse ox (oxygen saturation) every morning because that really was the only way you knew if she was having difficulty. Before the fall (8/23/23) she normally ran between 93% and 95%. After the fall it was 88% to 91%- 92% that is as high as she would get. In between the 2 falls she was weak. She was bound and determined to keep doing things the way she wanted. We were encouraging her to let us help her. She needed assist of 1. We were doing increased monitoring checking on her. The second fall (8/28/23) it was during a fire drill. I had a CNA come and tell me she couldn't get the (R4's) door open and she thought someone is in there. I went and tried to get the door open, and I couldn't either. I did get it open a little and I saw feet. I was calling maintenance and managers because we had to get that door open to find out who it was and help them. At one point they thought they might have to call the fire department to come in through the window. I told them do whatever but we gotta get in there. I then remember we have (V3) she is tiny. She was	S9999		

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working that day, so she came, and she was able to squeeze through. (V3) pulled her enough so the door would open. She was found face first on the floor. Her oxygen level was low. The paramedics came and took over. I remember it was a new CNA , I don't remember who, that was taking care of her that day and she did tell me that she had seen (R4) earlier."

On 10/31/23 at 10:40 AM, V13, LPN stated, "(R4) stayed in her room. She was independent. She would go to the bathroom by herself. She sat in her recliner. She took her meals in her room. I don't remember her using the call light that often. She didn't ask for a lot. She was in the first room on the left so she couldn't have gotten any closer to the nurses station."

On 10/31/23 at 10:47 AM, V14, CNA stated, "Before the bad fall the shower aide would give (R4) her showers. She was able to walk by herself. She would use the light to call for things like hot chocolate or tissues. I don't remember her needing more help between the falls."

On 10/31/23 at 10:50 AM, V15, CNA stated, "I was here the day she fell but she wasn't on my set. She refused for anyone to help her. She refused her oxygen. She did everything by herself. You would ask her if she needed to go to the bathroom and she would tell you "no" then you would catch her taking herself. She wasn't any different after the first fall she was just the same."

On 10/31/23 during separate interviews, between 12:40 - 12:45 PM, V11, V14 and V15 all stated that they did not notice R4 having a limp. V11 stated, "I only saw R4 walk maybe twice."

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On 10/31/23 at 2:23 PM, V18, RN (Registered Nurse) / MDS / Restorative Nurse, stated that when someone falls, we downgrade their transfer status until Therapy can evaluate them and all interventions can be put into place that way staff are just not continuing to let them do what they were doing when they fell so they don't fall again. V18 also stated that she is unsure why R4 did not get downgraded for her transfer status or why it took 5 days to get an order for Physical Therapy for R4.

On 10/31/23 at 2:46 PM, V1, Administrator, stated that his expectation is that a therapy order should have been written before 8/28/23 so she could have been assessed sooner. V1 also stated that he is unable to locate the root cause analysis for R4's fall on 8/23/23.

On 10/31/23 at 3:05 PM, V22, Director of Operations, stated that it is unknown if R4's shoes were ever assessed.

2. R1's Admission Profile documents that R1 was admitted on 12/3/21 and has diagnosis of Lung cancer, Alzheimer's, hemiplegia, and Hemiparesis following a stroke affecting the right dominant side.

R1's MDS, dated 6/18/23, documents that R1 is severely cognitively impaired and requires supervision with physical assistance from 1 staff member for transfers, walking in room and in the corridor, locomotion on and off the unit, toileting, hygiene, and dressing.

R1's MDS, dated 9/18/23, documents that R1 is severely cognitively impaired and requires extensive physical assistance from 1 staff member for bed mobility, transfers, walking in

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room and in the corridor, locomotion on and off the unit, toileting, hygiene, and dressing.

R1's Health Status Note , dated 9/10/2023 at 12:10, "Note Text: Writer was notified by staff that the resident was on her knees in her room. Writer observed the resident in a "praying" position in front of her recliner with her hands fold and head in seat of chair like she was praying. Writer asked resident how she got like that. The resident stated that she did not fall, she was walking to push her tray/bedside table to the foot of her bed and when she turned back around to walk to her recliner, she felt weak/dizzy. She stated she lowered herself to the floor that she didn't fall. Writer and another staff member assisted her off the floor and into her recliner. No injuries were noted but she had carpet imprints on her knees that were starting to fade. Resident denies any pain of discomforts. She is able to move all extremities without difficulties. She takes scheduled pain medication. Resident denies any new pain just the previous discomforts we are treating. MD notified. All parties notified. Will continue to monitor."

R1's Fall Investigation, dated 9/10/23, documents, "IDT (Intradisciplinary Team) meeting held with DON (Director Of Nurses) ADMIN (Administrator), MDS (Minimum Data Set) therapy and nurse managers. Root cause identified as residents noted to be dizzy and having increased confusion. Intervention: change transfer status to 1 - assist, MD (Medical Doctor) to review medications possibly rule out UTI (urinary tract infection) r/t (related to) increased confusion."

R1's Fall Investigation, dated 9/12/23, documents, "resident noted to have UTI , Hospice

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MD aware and treating with ATB (antibiotics) at this time."

R1's Health Status Note, dated 9/11/2023 18:15, documents, "Note Text: Writer was notified that the resident was on the floor in her room. The resident was observed on the floor in front of her bathroom with her back up against the door frame and her legs extended out in front of her towards the door. Resident was incontinent no shoes on but had socks on. Resident is c/o pain and discomforts when we attempt to move her. She states she is unaware if she is injured or not. Writer spoke with DON and about sending her to the hospital. Writer also spoke with the residents POA, and she stated she would like for her to be seen as well. Writer called and informed hospice of the occurrences and that we are sending her to the ER for evaluation and treat. Ambulance is en route to the facility to pick up resident."

R1's Health Status Note, dated 9/11/2023 22:37 Health Status Note, documents, "Note Text: resident returned to facility per transport and staff assist of one, rec'd (received) ct (computed tomography) and numbers x-rays of all extremities, results of questionable fractures of the tuft of the distal third digit, returned with sling resident can wear as per request, does not want on at this time, states is not hurting at this time, able to move, swollen as prior to fall no bruising noted at this time, neuro checks restarted, wnl (within normal limits) possible avulsion fracture, mild degenerative changes."

R1's Fall Investigation, dated 9/12/23, documents, "Intervention: reassess toileting plan, encourage to assist to recliner after meals."

R1's Health Status Note, dated 9/13/2023 08:29,

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S9999	Continued From page 18 documents, "Note Text: Resident found per CNA sitting on floor in front of her recliner. She couldn't verbalize how she ended up there. VSS. (vital signs stable) Denies pain. ROM WNL (range of motion within normal limits). No apparent injuries. Call light in reach. POA (power of attorney) sister notified." R1's Fall Investigation, dated 9/13/23, documents, "IDT meeting held with DON, ADMIN, and clinical nurse, Root cause identified as resident increased confusion BIMS (Brief Interview of Mental Status) of 5 and all needs were met at that time. Intervention: bed alarm, chair alarm, and w/c (wheelchair) alarm." R1's Health Status Note, dated 9/13/2023 08:59, documents, "Note Text: CNA came to get me to notify resident was on the floor. Observed resident sitting on buttock, feet out in front of her and it appeared she slid out of recliner. Assessed resident for any injuries, none noted and no c/o pain. Vitals obtained, ROM w/o any pain observed. Transferred resident back to recliner via (mechanical lift). MD/POA notified." R1's Health Status Note, dated 9/13/2023 12:28, documents, "Note Text: Resident noted to have increase in falls. Intervention for bed, chair, and w/c alarms. POA gave verbal consent and is aware of plan of care. MD aware." R1's Health Status Note, dated 9/14/2023 20:45, documents, "Note Text: CNA (V23) was walking past the resident's room and noted her sitting on the floor in front of her recliner. This writer was notified, and resident assessed. No injury noted and has FROM (full range of motion) to extremities. She did not hit her head. Alarm in place and alarming. (R1) is attempting to get up	S9999		

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and is sliding to the floor. Educated again on using her call light for help. She remains non-compliant. Isolation precautions continue due to ESBL (Extended Spectrum Beta-Lactamase) of the urine. No AR (adverse reactions) from ABT (antibiotic). Intervention is to ensure legs are elevated when in recliner and ensure alarm in place and active. Assist toileting at least every 2 hours and frequent checks. 142/78-76-20-98.9, SAO2 (oxygen saturation) 95% on RA (room air)."

R1's Fall Investigation, dated 9/14/23, documents, "IDT meeting held with ADMIN, MDS, DON, and Therapy. Resident continues to get up despite intervention. Intervention: 15-minute checks."

R1's Fall Investigation, dated 9/15/23, documents, "Went to (R1's) room and noted her on the floor behind her recliner. "IDT meeting held with ADMIN, MDS, DON, and Therapy. Resident continues to get up despite redirecting. Intervention: 15-minute checks."

R1's Fall Investigation, dated 9/23/23, documents, "Nursing Description: resident observed on floor in front of recliner. IDT meeting held with DON, ADMIN, therapy, and MDS. Root cause: resident continues to get up w/o (without) assistance. Resident stated at time of fall she had no pain but has c/o (complaint of) stomach pain and has had difficulty the past few weeks regarding ambulation and overall decline. Intervention: Hospice to review medication and evaluate for increase pain."

R1's Care Plan, dated 12/06/21 and revised on 9/15/23, documents, "Fall risk, history of stroke, COPD & other medical conditions that may cause weakness. Under hospice care, incont

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(incontinent) of urine at times, may try to get up without help. Interventions: 9/10/23 transfer status changed to one assist. 9/11/23 Evaluate for toileting plan. 9/11/23 MD to review medications. 9/12/23 Encourage to assist to recliner after meals. 9/13/23 Bed, recliner, and w/c alarms on at all times. 9/14/232 Hospice to assess r/t decline. 9/15/23 initiate 15 minute checks. 9/23/23 hospice to review medication. 12/6/21 Call light within resident's reach when in bed & at bedside. 9/15/23 Encourage and assist resident to toilet routinely and assist with peri care after incontinent episodes to help keep resident clean dry and odor free. 12/6/21 Keep pathway clear."

3. R5's Admission Profile, with print date of 11/2/23, documents that R5 was admitted on 11/24/21 and has diagnoses of Parkinson's Disease with Dyskinesia and repeated falls.

R5's MDS, dated 8/31/23, documents that R5 is cognitively intact and requires extensive assistance from 2 staff members for bed mobility, transfer, locomotion on unit, dressing, toileting, and personal hygiene.

R5's Health Status Note, dated 9/23/23 at 2:21 AM, documents, "Note Text: Resident found face down near the foot of his bed. Resident has advanced Parkinson's and has difficulty with speak, unable to understand what resident was attempting to state happened. Residents VS as follows 97.8, 95% RA, 108, 22, unable to obtain BP. Resident shook his head yes when asked if he was having pain. (V19) called and order received to send to (local hospital) for eval and treat. (ambulance) called and arrived at 0220. Sister called and message left to update on incident. On call notified at 0232."

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S9999	Continued From page 21 R5's Health Status Note, dated 9/23/23 at 6:00 AM, documents, " Resident returned from (local hospital) post fall. No new orders. No c/o pain or discomfort at this time." R5's Fall Investigation, dated 9/23/23, documents, "Resident found face down near the foot of his bed." It continues, "(Ambulance) called and arrived at 2:20 AM." IDT meeting held with DON, ADMIN, MDS, and therapy. Root cause identified as resident attempting to get out of bed, unable to state why. Intervention: Bolstered mattress." R5's Health Status Note, dated 9/27/23 at 2:35 PM, documents, "RN supervisor noted resident on the floor in front of the recliner RN yelled out for assistance . writer entered room noted resident lying on floor on left side, in a fetal position, recliner in high position resident denied any pain, was able to do range of motion per self , able to roll onto back per self , assessment done noted blood found abrasion to left brow /temple area, abrasion noted to left shoulder left knee and shin , areas cleansed B/P low other vitals stable, resident assisted to bed per assist of 3 and full body lift, ice pack applied to left eye /brow area at this time. resting at this time." R5's Fall Investigation, dated 9/27/23, documents, "IDT meeting held with DON, ADMIN, MDS, therapy. Root cause identified as resident used recliner remote to go home in the chair and slid out of chair. It had been previously discussed that resident use a manual chair and family was against that change. Intervention: reevaluate electric recliner. Provide assistance to and from meals. Bucket seat in wheelchair."	S9999		

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S9999	Continued From page 22 R5's Health Status Note, dated 10/7/23 at 9:13 AM, documents, "Resident lethargic this morning, falling asleep sitting up in w/c, cannot feed himself properly needs assistance from staff. Vitals taken bp98/68, p89, r18, T97.7, 02sat 97% RA. Negative for covid as of 10/7/23, writer did reach out to residents poa regarding resident's behavior, she stated "there is a new medication that he just started and thinks that is why he is acting strange" asked writer if she could hold medication until Monday when able to get in contact with neurology to possibly d/c med. Will continue to monitor." R5's Health Status Note, dated 10/7/23 at 11:46 AM, documents, "A visitor yelled down hallway where writer was located there is someone on the floor, upon arrival resident observed on bedroom floor positioned on his left side with left arm flexed behind him, writer and 2 other staff were able to reposition resident off of arm and collect vitals , bp 126/82, p126, o2sat 96% RA, assessment performed ,writer identified a small scrape located on residents forehead measuring approximately 1cm (centimeter) in diameter , erythema noted to left side of rib cage, resident denies pain during repositioning, does c/o pain when palpating area (mechanical lift) lifted off of floor on to bed. Life star Ambulance called to transfer resident to ER for evaluation, (V19) notified by phone, Poa notified by phone and is aware." R5's Health Status Note, dated 10/7/23 at 2:28 PM, documents, "Received call from resident's poa, stated resident will be admitted due to uti, kidney stone." R5's Fall Investigation, dated 10/7/23, documents, "A visitor yelled down hallway where	S9999		

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S9999	Continued From page 23 writer was located there is someone on the floor, upon arrival resident observed on bedroom floor positioned on his left side with left arm flexed behind him. 10/8/23 IDT met to discuss recent fall. RCA (root cause analysis): Resident got up on his own with the assistance of his electric wheelchair. Intervention: Electric wheelchair removed, and manual wheelchair placed in room. Care Plan updated." R5's Health Status Note, dated 10/24/23 at 2:27 AM, documents, "(R5) was heard moaning/yelling and upon entering his room he was noted on the floor beside his bed. He was laying on his stomach with his head facing the foot of the bed. Bed in low position. Body check completed and ROM to extremities at baseline with no pain noted. (R5) denies any pain. No injuries noted. Neuro check WNL. (R5) was then lifted back to bed using a (mechanical lift) lift and 2 staff. 120/70-72-18-98.2, SAO2 97% on RA." R5's Fall Investigation, dated 10/24/23, documents, "He has had an increase of trying to get up by himself and has had falls. Educated and reminded but is non complaint. IDT met to discuss recent fall. RCA: Resident got up on side of bed on his own and fell to floor. Resident was unable to state whey he was getting up. Intervention: Fall mat in place. Care plan updated." R5's Care Plan, dated 11/30/22, documents, "FALL RISK: (R5)is at risk for falls related to Deconditioning, Gait/balance problems, impulsive, may try to get up without help. He has diagnosis of advanced Parkinson's disease and is unsteady, has history of falls. Goal Minimize risk of falls through the review date 3/8/23. Interventions: 01/29/23 place frequently used	S9999		

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S9999	Continued From page 24 items within reach, provide grabber tool. 10/23/22 place wheelchair out of reach/site when up in recliner to prevent self transfer. 10/24/23 fall mat. 10/8/23 ER evaluation decline due to UTI, with antibiotics ordered. 0/9/23 (R5's) sister in agreement, to remove electric recliner from his room, and replace with a manual recliner 12/1/21 "Call, Don't Fall" sign in room. 1/11/22 Non-skid socks to be worn. 3/21/22 Low bed. 5/7/22 Check routinely on rounds due to noncompliant with call light system. 4/27/23 personal recliner assessment completed. Ensure that personal items are within reach 9/23/23 Bolster mattress 9/27/22 provide assistance to and from meals. Bucket seat in wheelchair 9/27/23 reassess electric recliner usage, communicate with sister for possible removal of the electric chair from his room 11/30/22 Call light within residents reach when in bed & at bedside Check on resident routinely with rounds, as resident does not use call light appropriately." On 11/2/23 at 2:30 PM, V22, Director of Operations, stated that she was involved in the IDT meeting for R1 and R5 falls. V22 stated that her suggestion was to move both R1 and R5 to a room near R6 because he has a full-time sitter around the clock so that way the sitter could keep an eye on R1, R5 and R6 all at the same time. V22 stated "I thought the previous Administrator (V24) and Director of Nurses (V25) did this but apparently, they didn't. There is no reason that (R1) should have that many falls in such a short time frame. (R5) is very impulsive, and he thinks he can get up by himself which he can't." V22 further stated that every fall should be investigated, a root cause analysis of the fall should be done, and new progressive interventions should be put into place to try and prevent future falls.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000756	A. BUILDING: _____ B. WING _____	C 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE HEALTH & REHAB CTR, THE	873 GROVE STREET JACKSONVILLE, IL 62650

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S9999	Continued From page 25 The policy Accidents and Incidents, dated 7/1/23, documents, "Policy: All accidents/incidents involving a resident will be documented in Risk Management. The nursing team will complete and investigation with the root cause and new interventions." It continues, " 4. Investigate and follow up Action: A. The Charge nurse must conduct an immediate investigation of the accident/incident and implement immediate appropriate intervention to affected parties. B. The Accident/Incident report must be completed." It continues, "E. The DON, IDT, and/or Designee will conduct an investigation of the accident/incident as well. Findings will be indicated in the appropriate area. The IDT will review with in 24 hour or next business day and discuss and attempt to find out the root cause and implement and appropriate intervention to attempt to prevent further falls. F. The Care Plan Coordinator will be notified of the accident/incident so that appropriated changes may be made to the care plan as needed." (A)	S9999		