STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013106	A. BUILDING: _____ B. WING _____	C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF COLUMBIA	253 BRADINGTON DRIVE COLUMBIA, IL 62236

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S 000	Initial Comments Complaint Investigation 2440194/IL168518	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)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. c) Each direct care-giving staff shall review	S9999		

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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 are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure a safe transfer was done for 1 of 3 residents (R3) reviewed for transfers in the sample of 6. This failure resulted in R3 being sent to the hospital and receiving 7 staples to his head.

Findings include:

R3's Physician Order Sheet for January 2024 documents a diagnosis of Unspecified Protein calorie malnutrition, Need for assistance with personal care, weakness, other reduced mobility, deforming dorsopathies, dysphagia, polyp of colon, barretts esophagus without dysphasia, disorientation, abnormal weight loss, Personal history of traumatic brain injury. R3 has an order for pureed diet, health shakes twice a day, super cereal at breakfast, and fortified pudding at lunch and dinner. Resident is also supposed to wear hip protectors every shift.

R3's Minimum Data Set, dated 12/18/2023, documents R3 was severely impaired for

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cognition. For eating he requires substantial /maximal assistance, dependent on staff for toileting, is dependent on staff for all efforts for chair/bed to chair transfer and does not walk.

R3's Care Plan documents (R3) requires assist with daily care needs related impaired functional and cognition deficits. Resident is dependent on staff for transfers, toileting, peri-care, dressing and grooming and eating. "(R3) is a high risk for falls related limited physical mobility, contractures, poor cognition, and poor safety awareness."

R3's Progress Notes, dated 1/5/2024 at 4:57 PM, Note Text: 4:28 PM: "Hall CNA (Certified Nursing Assistant) reported to this writer that the resident rolled out of the bed as she was preparing him for transfer, as she left to get assistance. Upon entry the resident was lying on his right side. Two open areas noted to the mid and left of his forehead. Resident moaning and grimacing in pain. ROM (range of motion) WNL (within normal limits), Contracted. Resident assisted back to bed x 2 attendants. 4:33 PM: EMS (emergency medical services) contacted for transport."

R3's Initial Report, dated 1/5/2024 at 4:28 PM, "Dependent resident who requires mechanical assist with transfers was observed on the floor from fall that resulted in 2 lacerations to right side of forehead requiring staples."

On 1/9/2023 at 12:22 PM, R4, Roommate of R3, stated,"(R3) was up in the air with the machine they use to pick you up and move you around. There was only one girl in her in the room when (R3) fell out. I did not know the girl; she was not one of our regular CNA's. I could see (R3) on the floor and there was blood everywhere even with

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my curtain pulled I saw him on the ground. Then when staff ran in here because there was a big boom the pad was still on the chair up in the air, and (R3) was on the floor and the pad was hanging with one hook. (R3) got a nasty cut on his head. Staff tried to then say (R3) fell from his bed and that is not true. He fell from the machine. He usually has two staff when they use that machine on him. That day he only had one staff. My curtain was pulled and I could see (R3) on the floor bleeding, and I saw the shadows through the curtain of him up in the air. Now they are trying to tell everyone he fell out of the bed and that is not true."

R4's Minimum Data Set, dated 10/19/2023, documents R4 is cognitively intact for decision making of activities of daily living.

R3's Investigation from 1/5/2024 documents a Statement from V6, CNA, "I dressed patient, cleaned patient up and put (mechanical lift) pad under patient. Curtain was pulled, bed in lowest position, Patient was resistance (sic), but I was able to do care. I left the room to get another CNA, we came back and (R3) was on the floor. We alerted the nurse, rolled patient side to side while nurse assessed him. Under the nurse's orders we lift patient into bed, nurse called EMS (emergency medical services)." Multiple attempts were made to contact V6 and she did not return any calls, and was not working in the facility during this survey.

R3's Fall investigation on 1/5/2024 documents a Statement from (R4), "Resident states it was only one CNA in the room during the event in question. Resident states the CNA entered the room, put the resident up in the (mechanical lift) and left out of the room to get some help.

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Resident states when the CNA re-entered the room (R3) fell out of the (mechanical lift) and on the floor. This nurse asked the resident was the position of his room curtain at the time of the fall in question, resident stated the curtain was closed but he saw the resident's shadow through the curtain so that's how he knows the resident was up in the (mechanical lift) at the time of the fall."

R3's Investigation from 1/5/2024 documents a Statement from V7, Licensed Practical Nurse (LPN), documents, " This writer was told by hall CNA that resident in room (R3's) room had rolled out of the bed and was bleeding from his head. CNA was asked how that happened. She stated that she had just cleaned resident up and placed him on a (mechanical lift) pad, she then stated she left the room to get assistance when she returned the resident was laying on the floor. Upon entry resident was laying on the floor on his right side, noted with two open areas to middle right side of forehead. After evaluation of the resident, I instruct both hall CNA's to assist resident back to his bed. I did not return until EMS arrived."

A Statement from V4, EMT (Emergency Medical Technician), dated 1/5/2024 at 4:38 PM, documents, "I responded to facility for a traumatic injury, Dispatch indicated a 69-year-old man fell from a (mechanical) lift and suffered two head injuries. On our arrival, nursing facility staff directed is to the patient's room in the 200 hall. We located the patient (R3) in his bed and retracted to his right side. Initial assessment on (R3) revealed he had two lacerations on left and right side of his bed as I stood at the foot end. He appeared alert and orientated x 0. His verbal response included moaning sounds. (V9) asked

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several facility employees what happened as they entered the room. No one could report on the incident, and indicated they were not with (R3). They didn't appear to know who was with him when the injury occurred. (V9) asked them to seek out they employee who was with (R3) when the injury occurred. One employee returned and indicated she could not locate the involved employee (s). (R3's) roommate (R4) recognized several employees who entered the room by name. He appeared alert and orientated x 4. He told us the staff uses the (mechanical lift) on him, and the device requires two people. He only saw one employee using the mechanical lift when (R3) fell from the device. He said, (R3) was way up there." We lifted (R3) from his bed to the stretcher with the use of bed linens. He continued to lay in a retracted position on his right side. He did not make any significant movements or appear he could sit up without full assistance. As we walked down the 200 hall with (R3) on the stretcher, we encountered another employee who identified herself as knowing about the incident. She stated (R3) did not fall from a (mechanical lift), but she found him on the floor next to his bed."

R3's Hospital Report, dated 1/5/2024, also documents, "EMS reports original EMS call was for patient falling out of (mechanical lift). EMS reports upon arrival nursing home staff reluctant to come with information about fall and reported patient fell out of bed. Patient's roommate who is alert and orientated x 4 reported to EMS the nursing home staff had patient in (mechanical lift) and dropped him out of (mechanical lift). Patient has laceration to left and right forehead. Patient is alert and orientated x 0. R3 received 7 sutures at the hospital for his head."

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S9999	Continued From page 6 On 1/9/2024 at 2:41 PM, V8, Local Police, stated, they (city) were contacted regarding the dispatch on 1/5/2024, and they stated they received a call on 1/5/2023 at 4:37 PM regarding a fall from a resident that was preparing to transfer with a (mechanical lift) and the resident fell. On 1/10/2024 at 9:48 AM, V7, Licensed Practical Nurse (LPN), stated, "I am an agency nurse I was working at the facility ,and the aid working on the 200/400 hall, I believe her name was (V6), came and got me and told me a resident had fell off the bed and was on the floor. I ran to the room and the resident has contractures and I saw that his bed bolsters were in place. (R3) was on the floor. The mechanical lift was in the room, but it was pushed to the side. I believe the pad was on the bed. (R3) was on the floor. There was blood and (R3) had a cut to his head. I asked (V6) to get help and transfer (R3) to his bed and I went and called for help. I did not assist with the transfer or with (R3) being transferred back to bed." On 1/12/2023 at 11:04 AM, V4, Emergency Medical Services Technician, stated, "We received a call from the facility alerting us that a resident was being transferred with the mechanical lift and fell from the machine. When I arrived at the facility, I got an interview with (R4), the roommate, who corroborated the event. When I tried to talk to staff, nobody knew anything, and nobody would admit that anyone had fallen. (R3) is so fragile, and thin and vulnerable. When we arrived at the facility, the mechanical lift was outside of the room, there was blood on the floor and on the mechanical lift. It does not make sense because they are the ones who made the call about someone falling from the lift."	S9999		

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S9999	Continued From page 7 The Facility Fall Policy, with a review date of 9/2023, 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 falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed." (B)	S9999		