STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000012	A. BUILDING: _____ B. WING _____	C 12/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE CLIFTON	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

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S 000	Initial Comments Investigation of Facility Reported Incident of December 3, 2023/IL167884	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)4)5) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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.

This REQUIREMENT is not met as evidenced by:

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S9999	Continued From page 2 Based on observation, interview, and record review the facility failed to maintain a mobility device within a resident's reach. This failure resulted R1 sustaining a fall, requiring hospitalization due to a Subdural Hemorrhage. The facility also failed to ensure a call light was within reach for R3, who has a history of falls. These failures affect two of three residents (R1 and R3) reviewed for falls on the sample list of three. Findings include: 1.) R1's Admission Diagnosis List dated 11/14/23 documents the following: Alzheimer's Disease with Late Onset, Unspecified Focal Traumatic Brain Injury With Loss of Consciousness of 30 minutes or less, Initial Encounter. R1's Admission Diagnosis List had a diagnosis added post-fall 12/03/23 as follows: "Traumatic Subdural Hemorrhage Without Loss of Consciousness, Initial Encounter." R1's Minimum Data Set (MDS) dated 11/24/23 documents R1's admission date as 11/14/23. R1's MDS also documents R1's Brief Interview of Mental Status score as five out of a possible 15, indicating severe cognitive impairment. R1's Baseline (Admission) Care Plan documents R1 has a history of falls and that R1 requires partial/moderate assistance transitioning from a lying to sitting position and a sitting to standing position. R1's Nursing Note dated 12/3/2023 at 3:49 pm documents: "V5 (Registered Nurse) called this nurse V6 (Licensed Practical Nurse) to resident's	S9999		

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S9999	Continued From page 3 (R1) room at approximately 15:18 (3:18 pm) and reported that resident (R1) had a fall. Resident was found sitting upright and leaning against her bed, being attended to by CNA (V8 Certified Nursing Assistant). CNA (V8) reported that she was just in her (R1's) room about 10 minutes ago. Resident stood up and walked without her walker and fell on the floor. She acquired a laceration/hematoma to her left forehead. She remained alert and oriented x (times) 1-2 (knows who she is, and where she is) per baseline. Area (left forehead) was cleansed, applied with (sic) an ice pack, covered with protective dressing, and vital signs taken. POA, (V14 Power of Attorney) and NP (unidentified Nurse Practitioner) notified and received order to send to ER (Emergency Room) for evaluation and treatment. Family requested to send her to (distant hospital-Emergency Room) and they will meet her (R1) there. Order to send out, POLST (Physician Order for Life-Sustaining Treatment), Face sheet, Order Summary, Bed hold order, and E-transfers sent with her. CNA (unidentified) removed her (R1's) hearing aids for safekeeping. Incident occurred at 1515 (3:15 PM); ambulance left at 1545 (3:45 PM). Phone update reported to (Emergency Department) nurse. VS (vital signs): BP (blood pressure) 96/64, T (temperature) 97.0, R (respirations) 16, P (pulse) 65, SpO2 (blood oxygen level) 98% (percent) RA (room air)." R1's Hospital report note dated 12/03/23 at 6:51 pm documents the following: "Chief Complaint, Patient presents with Fall, Large hematoma to head HPI (history of present Illness), (advanced age and gender identified) past medical history of dementia presents emergency department from (company name) nursing facility for a fall that occurred apparently while patient was on the way to the bathroom. She fell face first and hit her	S9999		

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S9999	Continued From page 4 head on the ground. They (unidentified) had stated that they (unidentified facility staff) did not think she lost consciousness. Upon arrival she is without her hearing aids and is very hard of hearing however does answer questions but given her history of dementia does not provide history. Family (unidentified) is at the bedside and states that she (R1) seems slightly tired and not as conversive as normal however, they (unidentified family) say it is difficult to have normal conversation with her (R1), given she is without her hearing aids at this time. Patient (R1) follows commands, moves all extremities and does complain of headache at this time." The same above report note documents: "CT (Computed tomography) cervical spine without contrast. Head - Large left frontal scalp hematoma. No calvarial fracture. There is a small, slightly heterogeneous hyperdense, extra-axial collection lateral to the left cerebral hemisphere, primarily adjacent to the left temporal lobe, measuring up to 5 (five) mm (millimeters) in thickness, compatible with an acute Subdural hematoma. No significant midline shift. Moderate chronic small vessel ischemic changes in the white matter. Small chronic left cerebellar infarcts. Moderate to severe global volume loss. Intracranial vascular calcifications. There may be partial mastoid effusions. Cervical spine no acute fracture or dislocation. Diffuse osteopenia. Marked degenerative changes are seen, most severe at C5-C6, similar to prior. Mild multilevel spondylolisthesis is similar to prior exam. Prevertebral soft tissues are grossly unremarkable." The same note documents: "ED Course and MDM (Medical Decision Making) Basic blood work was ordered as well as X-ray of chest and pelvis. CT noncontrast of head and neck were obtained. Discussed patient with	S9999		

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neurosurgery I spoke to the (V15, Physician Assistant) who discussed patient with (V16, Physician Neurology Department). Blood pressure did become elevated 190/92 (measured) so Hydralazine 10 mg was given, patient will need systolic blood pressure goal less than 140 given Subdural hematoma. Chest X-Ray without acute disease. X-ray of pelvis and left hip without acute fracture dislocation of prosthesis. Discussed with hospitalist, they were agreeable to observation for Subdural hematoma (collections of blood leakage in the brain post- trauma)." The same Hospital report documents "Emergency Department to Hospital Admission on 12/3/2023. Repeat CT (Computed tomography) noncontrast of head was ordered for 4:00 am in the morning giving evidence of Subdural on her CT upon arrival."

R1's facility Nursing Note dated 12/4/2023 at 09:16 am documents the following: "Note Text: IDT (Interdisciplinary Team) reviewed: root cause found to be resident (R1) ambulating without walker. Resident also has severe Alzheimer's disease. Resident currently at (distant hospital) for observation."

R1's Nursing Note dated 12/6/2023 at 11:07 am signed by V2 (Director of Nursing) documents: "Note Text: IDT team reviewed root cause to be ambulation without walker. Resident gets frustrated when walker and wheelchair are not close to her proximity. Will ensure that resident has wheelchair close to bed when she is in her room."

R1's Nursing Note dated 12/8/2023 at 12:21 pm, signed by V2 (Director of Nursing) documents: "Care Plan Note, Note Text: Keep walker and wheelchair in locked position, near bedside. Bed

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S9999	Continued From page 6 rail for mobility to prevent falls." R1's fall "Follow Up/Final Report Summary" dated 12/08/23 documents R1 stated "She (R1) walked without her walker." On 12/22/23 at 11:37 am V6 (Licensed Practical Nurse/LPN) stated "I (V6) was passing medication on the C-hall. I was called by (V5 Registered Nurse) the other nurse." V6 stated "When I got to (R1's) room, (R1) was leaning up against the bed, and (V8 CNA) was cleaning up blood. There was a lot of blood. I assessed (R1), she never lost consciousness. I got ice and had (V8) assist (R1), to hold it (ice pack) on her forehead. I went to get the treatment cart to do first aide. It had only been about 10 minutes since I had seen (R1). She was seated in her chair. The CNA (V8) who saw her on the floor thought (R1) got up without her walker to go to the bathroom. (V8) said (R1's) walker and wheelchair were across the room. I was focused on providing (R1's) care. I just took her word for it. I called the physician and family. Family wanted her to go out to the hospital." On 12/22/23 at 12:17 pm R1 was seated on the side of her bed. R1 had a one-inch scab on her left forehead. R1 also had one large bruise that extended over her left forehead, left side of her face, left side of her nose, left cheek and left neck. R1's bruise was reddish-purple, with fading yellow- green edges. R1 had no recall of falling. On 12/26/23 at 9:40 am V2 (Director of Nursing) stated "(R1's) fall on 12/03/23 was deemed to be caused by (R1) getting up on her own without using her walker or her wheelchair for mobility. (R1's) walker or locked wheelchair should have been at (R1's) bedside within reach."	S9999		

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S9999	Continued From page 7 On 12/22/23 at 2:45 pm V11 (Physician) stated he is not R1's Physician, V10 (R1's Physician) is out of town. V11 stated V11 can only speak in general. V11 stated the seriousness of a Subdural hematoma varies. The elderly person's vessel weakens over time. A fall that causes a Subdural hemorrhage can be minor or very serious. "The fact (R1) was kept overnight in the hospital for observation certainly indicates there was a concern that required observation of the Subdural hemorrhage and likely repeat a CT." 2). R3's Diagnoses List, with multiple dates, includes the following diagnoses: Essential Hypertension, Pain, Unspecified, Other Symptoms and Signs Involving The Musculoskeletal System, Muscle Weakness Generalized, Myalgia, Unspecified Site, Dementia, Unspecified Severity, Anxiety, Alzheimer's Disease, Unspecified, History of Falling, and Repeated Falls. R3's Minimum Data Set (MDS) dated 10/27/23 documents R3 has a history of falls and R3 has had one fall since the last assessment with no injury. R3's Care Plan dated 8/16/23 documents the following: "The resident (R3) is at risk for falls r/t (related to) Confusion, Deconditioning, Gait/balance problems, History of falls, (and) Incontinence." The same Care Plan documents: "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed." R3's Fall Report dated 8/14/23 documents the following witness statement, written by V18 (Registered Nurse): "One CNA (unidentified) was	S9999		

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S9999	Continued From page 8 in the assisted dining and was feeding another resident (unidentified) at the time. Resident (R3) stood up on her own and fell. V18's witness statement also documents "(R3) was restless as is her norm." On 12/22/23 at 9:08 am, R3 was in her room, seated in a reclined, geriatric wheeled chair that was approximately four feet away from R3's bed. R3 was reaching with her left hand, over the side of the left side of the chair and towards her call light cord. R3's call light cord was attached to the bed linen on the bed. R3's right buttock was off the seat of her reclined chair, as R3 shifted R3's weight to a left side lying position. As R3 leaned, surveyor entered the room and asked if I could get a staff member to help R3. R3 stopped leaning and sat back down in her geriatric wheeled chair. R3 shook her head yes confirming R3 would like surveyor to alert staff that R3 had a need for assistance. R3 pointed to her call light, four feet away from her geriatric recliner chair, and stated "That is what I want." On 12/22/23 at 9:10 am V4 (Licensed Practical Nurse) confirmed R3's call light was out of R3's reach. V4 stated "R3 has a history of falls, and her call light should be in her chair, so she does not have to reach for it." The facility "Fall Prevention Policy" dated as retrieved 12/2023 documents the following: "Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the	S9999		

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S9999	Continued From page 9 program to assure ongoing effectiveness." The same policy included the following: Fall/safety interventions may include but are not limited to: Direct care staff will be oriented and trained in the Fall Prevention Program. At the time of admission and in accordance with the plan of care the resident will be oriented to use the nurse call device. The nurse call device will be placed within the resident's reach at all times. The location of the placement will be verbalized for those residents with visual deficits. The resident's personal possessions will be maintained within reach when possible. These items include tissues, water, drinking glass and phone. Assistive devices such as walkers and canes will be placed within reach of those residents who have physician's orders to ambulate independently. "B"	S9999		