| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004840 | A. BUILDING: _____ B. WING _____ | C 08/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| JACKSONVILLE SKLD NUR & REHAB | 1517 WEST WALNUT STREET JACKSONVILLE, IL 62650 |

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| S 000 | Initial Comments<br><br>COMPLAINT# 2446235/IL176457 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.1210b)<br>300.1210c)<br>300.1210d)6)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br><br>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. | S9999 | | |

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| S9999 | Continued From page 1 | S9999 | | |

These requirements are not met as evidenced by:

Based on interview and record review the facility failed to provide safety and supervision for 1 of 3 (R3) residents reviewed for falls. This failure resulted in R3 falling, obtaining a laceration to the head, sutures and experiencing pain.

Findings include:

R3's Care Plan documents 6/28/23, documents that (R3) has a Self-Care Deficit As Evidenced by: Needs assistance with Activities of Daily Living (ADLs). It also documents Bed Mobility and Dressing require - One person physical assist required. R3's Care Plan continues (R3) is at risk for falls and injuries related to (r/t) cognition deficit and history of fall with fx. I have impaired mobility and lack safety awareness due to (d/t) my diagnosis (dx) of dementia.

R3's Minimum Data Set, dated 6/13/2024, documents that R3 is dependent on staff for Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support.

R3's Progress Note, dated 8/1/2024 at 5:15 AM, documents "Nursing Note Late Entry: Note Text: Upon entering residents' room the resident was sitting on floor by roommate's bedside with Nurse's Aide (V8) sitting beside the resident. Resident noted to have a Laceration to their center of their forehead. I cleaned the resident's injury and applied a band aide to injury. Notified Hospice Care Team who recommended resident be sent out to ED (emergency department) for further evaluation along with Physician (V9) recommending the same as above stated.

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| S9999 | Continued From page 2 | S9999 | | |

Notified residents emergency contact (V10) and on call Nurse (V3), ADON who verbalized an understanding of situation."

R3's Progress Notes, dated 8/1/2024 at 5:15 AM, documents "Change of Condition / Transfer Late Entry: Note Text: (R3) was transferred on a gurney via ambulance to acute care hospital Sent To: (Local) Hospital Date: 8/1/2024 5:15 Sent From: (Facility) Unit: Unit West Reason(s) for Transfer: Trauma (fall-related or other) -- head injury MD notified of transfer. See Transfer Form for other details.

R3's Progress Note, dated 8/1/2024 at 8:34 AM, documents "Nursing Note Text: Resident returned from (local) Hospital per facility transport in wheelchair."

R3's Progress Note, dated 8/1/2024 at 12:54 PM, documents "Nursing Note Text: Resident wincing with movement to arm/hand. Resident received scheduled Tylenol, still wincing/frowning/guarding arm/hand when attempting movement. Call to Hospice, Spoke with (V11 Case Manager.) NEW ORDER: Tramadol 50 mg q 6 hours for pain. Call to (V10), informed of new order."

R3's Incident Report, dated 8/1/2024, documents that R3 had fallen from sliding off the bed. It also documented V8's statement: 8/2/2024 "I was getting the resident up for the day, I had her sitting on the side of the bed, with the bed elevated. I was standing in front of the resident facing her and I went to grab the bed remote, which was stuck. At that time, I tried to grab remote with both hands to get it uncaught and the resident fell.

The Report Form-IDPH Notification form, dated

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8/7/2024, documents Fall with Injury. A comprehensive investigation was Initiated and showed that (R3) 88 YO female, non-independent transfer, dx dementia. Resident was sitting on the side of the bed being dressed by the aid with the bed elevated. CNA was standing in front of the resident facing her and went to grab the bed remote, which was stuck. At this time CNA tried to grab the remote with both hands to get it uncaught and the resident fell.

On 8/13/2024 at 11:10 AM V4, Licensed Practical Nurse (LPN) stated that R3 is the most pleasantly confused person. V4 stated that R3 is dependent on staff for care.

On 8/13/2024 at 11:13 AM V6, Certified Nurse Assistant (CNA), stated that R3 is dependent on staff for care. V6 stated that R3 cannot sit on the side of the bed independently. V6 stated that you must be directly in front of R3. V6 stated that R3 is also a picker. V6 stated that R3 reaches for and picks at things randomly. V6 this is why you have to be focused on her.

On 8/13/2024 at 11:16 AM V7, CNA, stated that R3 is dependent on staff for care. V7 stated that R3 cannot walk and requires assistance with transfers. V7 stated that R3 is not safe sitting on the side of the bed and cannot sit there independently. V7 stated that you have to be right in front of R3. V7 stated that R3 picks at stuff in the air, around her and reaches out randomly. V7 stated that you have to have your hands on R3.

On 8/13/2024 at 3:44 PM V12, LPN, stated that when he entered the room R3 was on the floor sitting on buttocks by roommate beds. V12 stated that he assessed R3 and then made the appropriate calls. V12 stated that R3 went to the

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| S9999 | Continued From page 4<br><br>hospital by ambulance and returned with sutures to her head. V12 stated that he was informed by V8, CNA, that she was assisting R3 with getting dressed. V12 stated that V8 had R3 sitting on the side of the bed. V12 stated that he was informed that V8 tried to grab the remote and turned her back for just a second and R3 fell face first onto the floor. V12 stated that R3 is alert and oriented to self only and was unable to communicate what happened. V12 stated because of this it is challenging to know when R3 is in pain. V12 stated that when it happened R3 did wince and whimper.<br><br>On 8/13/2024 at 6:00 PM V8, CNA, stated that she was getting R3 dressed. V8 stated that she raised R3's bed up and R3's feet were off the floor. V8 stated that she initially had her arm around R3 but then took it off R3 leaned to grab the bed remote and R3 fell face forward. V8 stated that it was her fault she (V8) had the bed to high.<br><br>The facility did not provide a Fall Prevention policy.<br><br>(B) | S9999 | | |