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
	IL6005748	A. BUILDING: ______ B. WING ______	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAR KA NURSING HOME	**201 SOUTH 10TH STREET MASCOUTAH, IL 62258**

(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 Annual Licensure Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.1210b) 300.1210c) 300.1210d)6 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 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.	S9999		

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These Requirements were NOT MET as evidenced by:

Based on interview, observation and record review, the facility failed to have fall interventions in place and implement progressive interventions in 3 of 7 residents (R6, R19, R36), reviewed for falls in the sample of 24. This failure resulted in R36 sustaining a head injury, requiring emergency room evaluation and treatment including but not limited to glue and adhesive skin closure strips to the right temple area.

Findings include:

1. On 9/17/24 at 9:05 AM, R36 was observed in her room in a low bed with a mat to left side of the bed, the call light was behind the bed, not within reach. R36 had bruising noted to the bilateral eyebrow areas with adhesive closure strips in place to the right eyebrow area. R36 stated she fell recently and that is how she got the bruising. R36 stated she has fallen 3-4 times and has gotten hurt each time. R36 stated she tries to get up on her own and falls, unsure of why she falls, she just does. R36 stated she uses her call button when she needs help and stated "it's usually clipped here (reaching on the right side of the bed), but it's not here." Surveyor moved the call light within resident's reach and she pushed it. Staff came into the room to see what R36 needed and R36 stated she was just checking to make sure it worked. R36 stated she had a headache and would like something for it.

R36's Face Sheet, undated, documents R36 has a diagnosis of Dementia, Tremors and Hypertension.

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R36's MDS (Minimum Data Set), dated 7/16/24, documents R36 has a BIMS (Brief Interview for Mental Status) score of 10, indicating R36 has moderate cognitive impairment, requires partial/moderate assist with toileting, requires substantial/maximal assist with sitting to standing, requires substantial assist with transfers and has a history of falls.

R36's Care Plan, dated 5/23/24, documents R36 has actual/potential risks for falls with the following interventions: 5/23/24 be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; 8/24/24 continue to educate resident that she needs to be patient and wait for staff to be available to assist; 8/28/24 continue to educate resident to wait for staff to assist her and she will need to ask for assistance; 9/12/24 sent to the emergency room for evaluation and treatment, received 2 adhesive skin closure strips and glue to the right temple and then was sent back to the facility; 9/14/24 continue to educate resident on waiting for staff for transfer needs and encourage her as much as she will allow to stay in high traffic areas. The Care Plan goes on to document R36 has an ADL (Activities of Daily Living) self-care performance deficit with an intervention to encourage her to use the call light and she requires 1-2 staff to assist in all transfers using a mechanical lift. The care plan fails to identify progressive interventions to prevent falls but utilizing the same intervention for multiple falls.

R36's Progress Note, dated 7/11/24 at 9:40 AM, documents the following: Writer called into residents room by CNA. Resident was attempting to transfer herself into bed unassisted, she stood up and slid down the front of her chair onto the fall mat on the floor. Skin assessment completed,

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no injury or wounds noted. Resident denies any pain or discomfort. Resident assisted up into bed and is now resting quietly in bed with HOB elevated and call light in reach. Fall mat in position and bed in low position, will continue to monitor.

R36's Progress Note, dated 8/24/24 at 12:16 AM, documents the following: Resident roommate summoned this nurse to resident room. Upon entering room resident was found in a sitting position on floor near bed. No internal/external rotation noted. Fall unwitnessed neuro checks initiated at this time. Assisted off floor with the help of two and placed into bed. Resident able to MAE WNL. Denies pain or discomfort.

R36's Progress Note, dated 8/29/24 at 9:56 AM, documents the following: Resident noted to be sitting on the floor in the hallway, in front of wheelchair. Resident noted with a 2 cm (centimeter) hematoma to the left side of the forehead. Resident stated "I leaned forward to pick something up and fell out of w/c."

R36's Progress Note, dated 9/12/24 at 4:35 PM, documents the following: Resident found on floor in room after this nurse was notified by resident's roommate. BP: 116/66, P: 76 Temp: 98.4, O2: 96, res complaining of head pain, 3 cm laceration noted to right temple, ecchymosis noted to left temple, no other injuries noted. MD and POA notified. EMS (Emergency Medical Services) transported resident to the hospital. report given to ER (Emergency Room) charge nurse.

R36's Progress Note, dated 9/12/24 at 9:46 PM, documents the following: Resident returned to facility from the hospital via EMS. Resident was transferred into bed via 2 EMS attendants. 2

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Steri-strips and Dermabond was applied to resident's right eyebrow in hospital. Resident had no complaints of pain or discomfort.

R36's Progress Note, dated 9/14/24 at 9:30 AM, documents the following: This nurse was alerted to resident being on the floor by resident's roommate. I went into room, found resident laying on the floor next to bed, resident was assessed for injuries, no injuries were found, resident's neuro-check was normal & vitals were stable. Once assessment was completed, resident was transferred from the floor to the bed. Resident states she was trying to transfer self from wheelchair to bed & fell, denies any pain or discomfort at this time, will continue to monitor for changes. POA, MD & DON notified.

R36's Hospital After Visit Summary, dated 9/12/24, documents a diagnosis of Fall and Laceration to the Right Eyebrow.

2. R19 Fall Risk Data Collection Form dated 8/24/24 documents R19 is high risk for falls.

R19 Minimum Data Set dated 8/23/24 documents for rolling right to left R19 is dependent and going from chair to bed R19 is dependent.

R19's Care Plan dated 8/5/24 documents (R19) is at risk for falls 7/30/24 fall with no injury and 8/9/24 fall with no injury. The resident will be free of minor injury through review date. The resident (R19) will be free of minor injury through review date. Interventions: The resident (R19) will be free of minor injury through review date. Hospice nurse to review medications resident has a floor mat next to bed while in bed. Bed in lowest position. Resident is in a broda chair

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R19's Fall Investigation dated 12/2/23 documents resident fell out of wheelchair to floor and hit head.

R19's Fall Investigation dated 1/17/24 documents notified by CNA (Certified Nursing Assistant) that the resident (R19) "had fell". Upon entry to the room resident (R19) noted sitting on the floor next to her bed. Sitting on floor on bottom with legs extended forward resident moving all extremities CNA stated resident (R19) fell backward onto floor.

R19's Fall Investigation dated 2/8/24documents resident (R19) found on the floor lying on her left side near the bed. The fall (was) unwitnessed, (and) neuro checks started at this time. The resident (R19) assisted off the floor.

R19's Fall Investigation dated 2/25/24 documents resident (R19) found on the floor near her bed, in her room there was a small goose egg area near the top of her scalp. small amount of blood from a small skin tear. Pressure applied, dry dressing applied, seemed a bit restless PRN tramadol and Ativan was given.

R19's Fall Investigation dated 3/6/24 documents resident (R19) found on floor by her bed.

R19's Fall Investigation dated 6/6/24 found resident (R19) sitting on her buttocks in the doorway resident unable to explain what happen.

R19's Fall investigation dated 6/20/24 resident (R19) noted by staff sliding out of bed onto the floor mat. med review completed floor mat.

R19's Fall investigation dated 7/30/24 resident (R19) taken to room to see if resident needed to

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be changed. Resident note to be screaming louder resident was noted actively sliding out of bed.

R19's Fall investigation dated 8/3/24 resident (R19) found lying on her left side in the dining room.

R19's untitled Fall Intervention form dated 1/17/24 documents the fall intervention is med review completed continue with med A.

R19's untitled Fall Intervention form dated 2/1/24 documents continue with skilled therapy services for safety transfers.

R19's untitled Fall intervention Form dated 2/8/24 documents care plan meeting held 2/7/24 via phone with POA (power of attorney) discussed hospice for next level of care. R19's untitled Fall Intervention form dated 3/6/24 documents contacted hospice nurse to perform a med (medication review).

R19's untitled Fall intervention form dated 6/6/24 documents hospice nurse updated and came out for a visit will review medications.

R19's untitled Fall intervention form dated 6/20/24 documents floor mat. The untitled Fall Intervention form dated 7/30/24 documents hospice nurse to review medications due to increased anxiety.

R19'sUntitled Fall Intervention form dated 8/5/24 documents spoke with hospice nurse to review different medication for anxiety regimen. R19's POS (Physician Order sheet) Dated 8/5/24 documents Alprazolam 1mg every four hours when ever needed for anxiety.

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R19's untitled Fall Intervention form dated 8/24/24 documents resident is in a Broda chair.

0n 9/18/24 at 4:20 PM V3 Minimum Data Set (MDS) coordinator stated, "she has had a lot of falls, and we have to reuse some of the interventions. We resolve them and use them again."

3. R6's Face Sheet documents R6 was admitted to the Facility on 9/17/09 with diagnoses including Alzheimer's disease, muscle weakness, unsteadiness on feet, and need for assistance with personal care.

R6's Minimum Data Set (MDS) dated 4/11/24 documented R6 was severely cognitively impaired, independent with bed mobility and transfer, and used wheelchair.

R6's Care Plan initiated 8/3/19 documents R6 is at risk for falls related to history of falls, need for assistance with activities of daily living, incontinence of bowel and bladder, and diagnosis of dementia with poor safety awareness.

R6's Care Plan Intervention initiated 8/3/19 documents R6 will have anti-tippers to wheelchair at all times.

On 9/18/24 at 11:30 AM, R6 was sitting in her wheelchair in the dining room with other residents. There were no anti-tippers on the wheelchair.

On 9/19/24 at 12:40 PM, R6 was sitting in her wheelchair in the dining room feeding herself lunch. There were no anti-tippers on the wheelchair.

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R6's Fall Risk Assessment dated 12/14/23 documented R6 was at risk for falls.

R6's Unwitnessed Fall Report dated 5/10/24 documents, "CNA came to the nurse saying res (resident) had blood all over her & was all over the floor beside the bed. Upon entering room, this nurse noted res's (resident's) face to be covered with dried blood and blood droplets were noted on the floor beside the res's WC (wheelchair)." "As CNA was wiping the dried blood off the res, a 2cm (centimeter) x 1cm hematoma with a 1cm gash in the middle was noted over the res's L (left) eyebrow." "Resident Unable to give Description."

R6's "After Visit Summary" from (Local) Emergency Room documents R6 was seen for a fall with the diagnoses forehead cut, head injury, and laceration repair with glue.

R6's Care Plan Intervention updated 5/10/24 documented, "Resident educated to ensure w/c (wheelchair) brakes are locked." (R6's 4/11/24 MDS documented R6 was severely cognitively impaired.)

R6's Unwitnessed Fall Report dated 6/3/24 documents resident was found on the floor in her room sitting on bedside mat, and R6 was unable to explain what she was trying to do.

R6's Care Plan Intervention updated 6/3/24 documents, "(R6) will continue to work with Med B therapy services on strengthening." No new interventions were added following R6's 6/3/24 fall.

R6's Unwitnessed Fall Report dated 6/13/24

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documents "Resident Unable to give Description." There was no "Nursing Description", and there were no details of the fall or potential causative factors.

R6's 6/13/24 Care Plan Intervention documents, "Continue with therapy services." No new interventions were added following R6's 6/13/24 fall.

On 9/18/24 at 1:12 PM, V17, Certified Nursing Assistant (CNA), stated most of R6's falls happened because she would forget to put on her wheelchair brakes when she was self-transferring.

On 9/18/24 at 2:40 PM, V19, CNA, stated R6 does not let staff know when she needs to transfer, so they often do not know she needs help until she is already done.

On 9/18/24 at 3:17 PM, V26, Occupational Therapist (OT), stated R6 has a tendency to do things herself and is unlikely to ask for help due to cognitive deficits, so they requested increased supervision by staff.

On 9/19/24 at 12:10 PM, V16, Licensed Practical Nurse (LPN)/Wound Nurse, stated R6 forgets her limitations and can take herself to the bathroom, but sometimes she rushes, and that is the problem. She stated interventions have been put in place, but there have been no changes in her level of supervision. She was unsure if R6 ever had anti-tippers on her wheelchair.

On 9/20/24 at 9:18 AM, V21, CNA, stated she does not think R6 has ever had anti-tippers on her wheelchair.

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On 9/19/24 at 1:44 PM, V1, Administrator, stated she will have to check into R6's anti-tippers. She stated she expects progressive interventions to be implemented after each fall and followed.

The Facility's "Fall Policy" reviewed 9/2024 documents, "The purpose of the Fall Management Program is to develop, implement, monitor and evaluate an interdisciplinary team falls prevention approach and manage strategies and interventions that foster resident independence and quality of life. The Fall Management Program promotes safety, prevention and education of both Staff and residents." "The Facility shall ensure that a Fall Management Program will be maintained to reduce the incidence of falls and risk of injury to the resident and promote independence and safety." "Following any falls, the facility staff completes an Occurrence Report. Details of the fall will be recorded and potential causal factors identified and investigated. Interventions will be implemented and Care Plan Updated."

The Falls and Fall Risk, Managing Policy, dated 12/2007, documents the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.

(B)

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Section 300.661 Health Care Worker Background Check

A facility shall comply with the Health Care Worker Background Check Act and the health Care worker Background Check Code.

This Requirement is NOT MET as evidence by:

Based on interview and record review, the facility failed to obtain conduct pre-employment screening and obtain results of fingerprint checks to determine if employees had a prior criminal history which would disqualify them for employment. This had the potential to affect all of the 42 residents living in the facility.

Findings include:

1. On 9/19/24, employee files were reviewed for pre-employment screening. The following was documented:

V22, Certified Nurse's Aide (CNA), was hired on 6/26/24. The facility initiated a fingerprint based criminal background check on 7/31/24, not within 24 hours of hire.

V23, Housekeeper, was hired on 7/19/24. The facility initiated a fingerprint based criminal background check on 7/31/24, not within 24 hours of hire.

On 9/18/24 at 10:13 AM, V1, Administrator, verified the hire dates of V22, CNA, and V23, Housekeeper. V1 stated she understands the employee background checks have to be done within 24 hours of hire.

The facility's Abuse Prevention and Prohibition

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Policy, with a revision date of 8/24/24, documents all employees will have criminal background checks, state and federal required checks.

The Long Term Care Facility Application For Medicare and Medicaid, CMS (Centers for Medicare & Medicaid Services) form 671, dated 9/17/24, documents that the facility has 42 residents living in the facility.

Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information

In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act).

This Requirement is NOT MET as evidence by:

1. On 9/19/24, resident files were reviewed for pre-admission screening. The following was documented:

R7's Census, documents R7 was admitted to the facility on 6/15/24. The facility initiated a fingerprint based criminal background check on 9/16/24, not within 24 hours of admission.

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R14's Census, documents R14 was admitted to the facility on 6/17/24. The facility initiated a fingerprint based criminal background check on 9/16/24, not within 24 hours of admission.

On 9/18/24 at 10:13 AM, V1, Administrator, stated she understands the employee and resident background checks have to be done within 24 hours of hire/admission, but she didn't have access to the system so had to have another building run them for her. V1 verified the dates on the top of the fingerprint background check was the date, 9/16/24, the check was ran on R7 and R14.

The facility's Identified Offender Policy was requested 9/19/24 and was never produced by the facility.

The Long Term Care Facility Application For Medicare and Medicaid, CMS (Centers for Medicare & Medicaid Services) form 671, dated 9/17/24, documents that the facility has 42 residents living in the facility.

(C)