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	IL6004493	A. BUILDING: _____ B. WING _____	08/22/2024

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GREENVILLE NURSING & REHAB	400 EAST HILLVIEW AVENUE GREENVILLE, IL 62246

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S 000	Initial Comments Annual Licensure Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 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. 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		

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S9999	Continued From page 1 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. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure resident was	S9999		

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supervised to prevent falls and implement effective fall prevention measures for 1 of 3 residents (R60), reviewed for incident/accidents, in the sample of 33. This failure resulted in R60 sustaining a fractured femur (broken leg bone), discomfort and a decline in functional status.

Findings include:

The Facility's Incident Log documents R60 experienced falls on: 6/4/2024 in the main lobby; 6/6/2024 in her bathroom resulting in a hematoma; two falls on 6/8/2024, both in R60's bedroom, with one resulting in an injury requiring a hospital admission.

R60's baseline care plan dated 5/14/2024 documents R60 is at Risk for falls and will not experience any injuries related to falls.

R60's Care Plan dated 6/4/2024, "Staff to offer help resident safely transfer to one of the chairs or couch in the dining room seating area after breakfast".

R60's Care Plan dated 6/6/2024 documents, "Offer resident to be laid down after meals".

R60's Care Plan dated 6/8/2024 documents, "Bed in lowest position while occupied" as well as "Fall mat to be placed next to resident bed while occupied. 15 minute checks will also be initiated upon return from hospital for 72 hours".

R60's Care Plan dated 6/12/2024 documents, "Verbally remind resident not to ambulate without assistance".

R60's Minimum Data Set (MDS) dated 5/21/2024 documents R60 is cognitively impaired and

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requires partial/moderate assistance to go from the sitting to standing position as well as ambulating.

R60's significant change MDS dated 6/19/2024 documents R60 now dependent for transfers.

The Facility's Resident Matrix dated 8/19/2024 documents R60 had a fall, a fall with injury and a fall with major injury.

The Facility's Resident Incident Report dated 6/4/2024 documents, "Resident alarm sounding from main lobby- resident attempting to self-transfer from w/c (wheel chair) in lobby and noted on left knee trying to get up. Wheels locked to w/c with left leg under and trying to stand back up with right foot on the ground and right knee next to chair. Denied pain or injury. Assisted resident to chair and no injuries assessed. Transferred back to w/c w/ (with) alarm in place. Immediate actions taken: assessed and transferred back to w/c with alarm under resident and taken back to common area".

The Facility's Resident Incident Report dated 6/6/2024 documents, "Resident transferred self to bed and fell onto knees. Immediate action taken: assisted to w/c and assessed for injuries none noted".

The Facility's Resident Incident Report dated 6/8/2024 at 10:30 AM documents, "CNA responded to alarm and noted resident on the floor in front of nightstand holding onto IV pole. CNA call[ed] for nurse. Resident assessed and assisted back onto the bed. Resident denies hitting head and denies pain at the time". There is no immediate action taken documented.

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The Facility's Resident Incident Report dated 6/8/2024 at 2:20 PM documents, "CNA and nurse responded to loud noise. Resident noted on her back in the doorway of residents room. Resident assessed and not moved d/t (due to) resident screaming in pain to neck head and left hip. No visual injury noted. Resident sent to ER (Emergency Room) for possible unseen injuries".

The Facility's Final Report to Illinois Department of Public Health dated 6/14/2024 documents the date of occurrence was 6/8/2024. The Initial Report documents R60 fell in the doorway of her room, began exhibiting signs of pain, was sent to the local Emergency Room, and was diagnosed with a fracture of the left femoral neck. It further documents, "On 6/8/2024 (R60) attempted to ambulate on her own without assistance from staff". "(R60) ambulated to the door of her room and when she got to the doorway she fell, landing on her left side. Nursing staff immediate assessed (R60), called her PCP (Primary Care Provider) and obtained orders to end resident to the ER (Emergency Room). Later in the evening the facility received a fax from the ER revealing a fracture of the left femoral neck. Resident was transferred to (metropolitan) hospital for further treatment of her injuries. Upon return the IDT (Inter-Disciplinary Team) assessed (R60) and determined that she is not ambulatory at this time due to mental status and physical limitations. IDT determines that based on the resident current state resident bed will be lowered to lowest position while occupied, a fall mat will be next to the bed while occupied, and resident will be placed on 15-minute checks for the first 72 hours following readmission".

R60's X-ray report dated 6/8/2024 documents, "Indication: Fell, left hip pain. Impression:

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Fracture of the left femoral neck".

R60's Progress Notes dated 6/8/2024 at 10:45 AM documents a Certified Nursing Assistant (CAN) responded to R60's personal alarm and noted resident was on the floor in front of nightstand holding onto the Intravenous pole. R60's wheelchair was placed at bedside in the locked position and reminded for her safety to use call light and wheelchair.

R60's Progress Notes dated 6/8/2024 at 2:20 PM documents a CNA and nurse heard a loud noise and responded, and resident was noted laying on her back in the door to her room with the wheelchair at her feet. R60 was yelling out in pain related to the back of her head, neck and left hip. R60's PCP was notified of the second fall, possible injuries and gave an order to send to the hospital.

R60's Progress Notes dated 6/12/2024 at 6:20 PM documents R60 returned to the Facility and was yelling/moaning out loud upon arrival and continued to moan throughout the shift.

R60's "Every 15 Minute Check Sheet" dated 6/12/2024 checks were implemented and was in bed moaning for several consecutive hours.

On 8/20/2024 at 11:36 AM V5, Certified Nursing Assistant (CNA), V10 Registered Nurse (RN) and V15, CNA stated R60 sustained a hip fracture while at the facility.

On 8/21/2024 at 8:58 AM, R60 was in bed. R60's bed was not in its lowest position. This observation was verified by a second surveyor.

On 8/21/2024 at 11:45 AM, V5 stated R60 is a fall

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risk and attempts to get out of bed unassisted. V5 stated R60's bed should be in the lowest position. V5 stated R60 is "smarter than you think. It's 'iffy' if she would remember directions given". V5 stated she would not consider reminders as an effective intervention and should be 1:1 supervision. V5 stated she has expressed her concerns to nursing staff and the Director of Nursing (DON). V5 stated R60 requires two staff members for assistance with ambulation/transfers.

On 8/21/2024 at 11:56 AM, V15 stated R60's bed should be in the lowest position and requires 1-2 staff members for assistance. V15 stated if none of the fall prevention interventions are working, staff must sit with R60.

On 8/22/2024 at 9:42 AM, V10, MDS/Care Plan Nurse stated, "We usually look at what interventions they have, look at what they already have in place, investigate what happened, look at other interventions in place to come up with more. One of the falls (R60) was using an intervention we already had in place, the wheelchair. We meet every morning, the next morning after it happens, we have an IDT meeting. The immediate intervention on this one was to keep her in a supervised area. Our intervention after that one was to transfer into one of the chairs. She was trying to transfer herself, so we go ahead and transfer her to the chair. (R60) had two falls on 6/8 (2024) one in morning, and one later. The IDT meeting probably wouldn't have been until the next day. That's the one I was just saying, we locked the wheelchair and put it by her, the second fall she was pushing the wheelchair. They had immediately put that intervention into place, they didn't document it on here (the Incident Report). That fall was on the weekend, the IDT

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meeting wouldn't have been until Monday. They call and notify (V1, Administrator) and (V2, Director of Nursing) of fall, and they ask them what did you do".

On 8/22/2024 at 9:43 AM V1 stated, "(R60's) (6/4/2024) fell in the common area. That wasn't the immediate intervention. She was in the front lobby. We were all in morning meeting. She tried to self-transfer, and they brought her to the circle/old nurse's station. IDT meetings are held every meeting after morning meeting. (R60's) 6/6 (2024) fall- the root cause was self-transfer. Most of the time she is trying to get herself from wheelchair to softer chair, so we try to transfer her before she does because she is always trying to transfer self into those chairs. She has been offered into one of those chairs but didn't want too today. The first fall (On 6/8/2024)-her wheelchair was not around her bed. She tried to get out of bed, held onto IV pole. The immediate intervention was to put wheelchair with wheels locked next to bed, but that then unfortunately led to next fall. She (R60) held onto wheelchair with breaks locked and used it as a walker. I watch it on video, the CNA had just laid eyes on her. I saw it in video. During this time, she had UTI (urinary tract infection) and was very confused and agitated. (R60's) alarm (position changing alarm) was not sounding on this one (second fall on 6/8/2024). It's care planned she has a history of turning it off. We put her alarm at the head of bed frame, I think she turned it off. Those interventions were the safest thing we could come up with".

The Facility's Fall and Fall Risk, Managing Policy dated March 2018, documents, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's

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S9999	Continued From page 8 specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling". It continues to document, "If falling recurs, despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant". It further documents, "Position change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner". It further documents, "If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously been identified. The staff and or/physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls". (A)	S9999		