STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008403	A. BUILDING: _____ B. WING _____	C 10/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTISH HOME, THE	2800 DES PLAINES AVENUE RIVERSIDE, IL 60546

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S 000	Initial Comments Investigation of Facility Reported Incident of 08-23-2024/IL178541	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710a) 330.710c)3) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. c) The written policies shall include, but are not limited to, the following provisions: 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to respond to call light request for assistance and failed to follow the plan of care assist with showers to include preparing the floor mat to reduce risk of falling for a resident assessed to be at fall risk. This affected one of three residents (R1) reviewed for falls and safety. This failure resulted in R1 waiting for over 30	S9999		

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S9999	Continued From page 1	S9999		

minutes for assistance after activating the call light for shower assistance. R1 subsequently attempted to shower which resulted in a fall incident in which R1 sustained a left rib fracture.

Findings Include:

Facility Reported Incident dated 8/23/24, reads in part: R1 was sent to hospital on 8/22/24 for further evaluation of left lower back and left abdominal pain. Later that evening, hospital reported resident admitted with intractable pain and possible UTI (urinary tract infection). Hospital called facility today for transfer back to facility and reported resident sustained left rib fracture. Investigation Initiated.

On 10/12/24 at 1:30pm interviewed R1. R1 reported having a fall recently, does not recall the date. R1 stated that R1 called for assistance and pulled R1's call light. R1 waited for more than 30 mins. R1 stated R1 could not wait any longer so R1 decided to take a shower herself and did not wait for assistance. R1 stated "that was a bad decision. Not asking and waiting for assistance". While in the shower R1 fell, and R1 scooted herself all the way out of the bathroom to her room door and yelled for help. The staff came right away. R1 stated three staff assisted R1 back to the wheelchair. R1 stated it felt good to be in the wheelchair and to sit on something soft at that time. R1 stated R1 remembers having tolerable back and side pain. R1 stated the pain worsened a day or two later. R1 stated pain increased with movement. R1 stated R1 remembers going to the hospital and returning to the facility. R1 stated R1 was not aware if she has fracture now, but reported that the pain is better, lesser pain than before.

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On 10/12/24 at 2:30PM, V3 (CNA/certified nursing assistant) stated that V3 was in the dining room helping out one of V3's residents getting ready for breakfast. V5 (Nurse) called V3 and asked if V3 could help get R1 up. V3 stated this was about approximately 7:30am because breakfast was about to start at 8am. R1 was laying on the floor, trying to sit up. R1 was crying... R1 stated something about falling in the shower. V3 does not recall if R1 was dressed but V3 believes it was just the towel. V3 does not recall if R1 was wet at the time. V3 stated the call light was not on when V5 and I went to go help her (R1).

On 10/12/24 at 330PM, V4 (RN/registered nurse, night nurse) stated that V4 had just given report to oncoming nurse. V4 stated V4 heard R1 screaming for help in R1's room. V4 stated V4 went into R1's room and observed R1 sitting on the floor outside of the bathroom. V4 stated R1 was closer to the bed in R1's room. V4 stated R1's room door was shut. V4 opened the door and that's when V4 found R1. V4 asked R1what happened and R1 stated R1 just took a shower and fell. V4 stated call light was not on. V4 told R1 V4 was going to get help. V4 called V5.

V4 stated R1 was assessed R1. There were three of us who assisted R1 in the wheelchair. V4 stated R1 reported no complaint of pain at that time. V4 was told that R1 usually takes her shower by herself in the morning. V4 stated that V4 works night, so V4 does not know R1's morning shower routine.
After Visit Hospital Summary notes dated 8/23/24. Treated for mechanical fall, rib fractures, ureteric stone during hospitalization.

On 10/12/24 at 1:45PM, V2 (DON/director of

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nursing) stated that hospital reported that R1 had a rib fracture on 8/23/24. V2 stated R1 was sent out on 8/22/24 but did not get the report about the fracture until the hospital was ready to send R1 back. V2 stated R1 was originally admitted with retractable pain and possible UTI and (Left rib fracture). V2 stated R1 went out on 8/22/24 because of increased back pain. V2 stated R1 reported that laying helps alleviate the pain. V2 stated R1 had a complaint of pain in left lower back and left abdomen and attending doctor ordered to send R1 out for evaluation.

V2 also stated that it was reported to the state as unknown injury and investigated. V2 stated R1 had fallen a few days prior. V2 stated R1 was getting out of the shower by herself and R1 was not supposed to get in the shower without assistance. V2 stated after that fall R1 was out and about and participating with meals, activities, and no complaint of pain. V2 stated "The way R1 was acting we really don't think we have reason to believe that there was injury. I have no way of proving that she had a fall and maybe R1 was not admitting to another fall. V2 talked to various staff and R1 was doing fine, prior to complaining of pain the day she was sent out on 8/22/24. R1 did not call for help and R1 decided to go take a shower on her own. R1 is in our sheltered unit because she is cognitively able to verbalize her needs and use the call light and ask for assistance. V2 stated she (R1) is independent and able to ambulate with walker. V2 stated R1 possibly had fallen again. V2 stated If R1 had fallen again, R1 is able to get up on her own. V2 stated R1 knows to ask for assistance but did not ask for assistance at that time.

R1 Fall Assessment dated 4/2/24 and 8/23/224, indicated R1 scored 45 or higher and is high risk

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S9999	Continued From page 4 for fall. Incident note on 8/18/24 at 10:24, reads in part: R1 was found in room on her bottom with a towel around R1. R1 stated that R1 fell while trying to get out of the shower. No visible skin tears or bruising noted. Neuro check was also done, and no abnormalities were noted. Resident is able to move all limbs and is alert and orientated x/times 4. Health Status Note on 8/20/24 at 21:57, reads in part: Resident stated she was in pain of her left abdominal area. Tylenol was given. Incident note on 8/21/24 at 13:53, reads in part: Resident post fall x2 days ago. Resident in bed most of day complaining of back pain. Incident note on 8/21/24 at 22:03, reads in part: day 2/3 post fall. R1 complained of pain or discomfort at this time. Health Status Note on 8/22/24 at 11:38, reads in part: Received R1 in bed awake, alert and verbally responsive. R1was crying and complaint of left lower back and left abdominal pain 10/10. Rx administered as scheduled including Acetaminophen. Attending doctor notified, received order to send to ER for further evaluation. Service plan dated 4/8/24. Reads in part: ADL/activities of daily living self-care performance deficit r/t/related to weakness, and essential tremors. BATHING/SHOWERING: Requires staff set up: laying out towel and clean clothing, preparing bathmat on floor, preparing water temperature, etc.	S9999		

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S9999	Continued From page 5 Falls and Prevention Policy dated 3.2022, reads in part: Based on current evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and go try to minimize complications from falling. The staff will input from the multidisciplinary team will implement a resident centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with history of falls. Monitoring subsequent falls and fall risk, of any additional falls and resident responses to interventions. Upon admission, the staff and the multidisciplinary team will seek to identify and document resident risk factors for falls and establish a resident centered falls prevention plan based on relevant assessment information. Assessment will include resident's history of falls. (B)	S9999		