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
	IL6005250	A. BUILDING: ____ B. WING ____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA SALLE COUNTY NURSING HOME	**1380 NORTH 27TH ROAD OTTAWA, IL 61350**

(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 Complaint Investigation: 2421682/IL170393	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)5) 300.1210d)3)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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999		

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allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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

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and assistance to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review the facility failed to implement fall interventions for a resident at risk for falls for one of three residents (R1) reviewed for falls in a sample of three. This failure resulted in R1 experiencing an unwitnessed fall, subsequently sustaining a left hip fracture requiring surgical repair.

Findings include:

R1's Admission Fall Risk Assessment, dated 2/2/24 documents that R1 is at risk for falls.

R1's Baseline Care Plan, dated 2/2/24, documents that R1 requires one-person physical assist for locomotion on the unit. This form documents that R1 is cognitively impaired. R1's baseline care plan does not have fall or safety interventions in place.

R1's Restorative/Rehabilitation Evaluation, dated 2/2/24, documents that R1 requires extensive assist of one person for transfers.

R1's Progress Notes, dated 2/11/24 at 6:45am, documents that R1 was awake at 4:15am. R1 was assisted to bed, but got out of bed. R1 was taken to the bathroom and fluids were offered, will continue to monitor.

R1's Progress Notes, dated 2/12/24, documents that at 8:30pm, V4 (Licensed Practical Nurse/LPN) kept R1 by her side, due to R1

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repeatedly trying to walk. R1 was given a stuffed animal to hold. V4 documented that she came out of a room after giving a medication and heard R1 say AH! R1 was rubbing her left knee. V4 documented that R1's knees were checked for injuries, but none were noted. R1 was asked if she could move her legs, which she did. R1 was assisted up to her wheelchair. R1 progress notes document that R1 was rubbing above her knees. V6 (R1's Primary Care Physician) gave orders for hip and knee x-rays.

R1's Progress Notes, dated 2/13/24 at 12:45am, documents that R1 was crying out with facial grimacing and grabbing her left leg and hip area. R1 was sent to the emergency room for suspected hip fracture. At 4:14am, V3 (Registered Nurse) documented that R1 was being admitted to the hospital for a left hip fracture.

V9's (Certified Nursing Assistant) signed Witness Interview Form, dated 2/12/24, documents that Resident (R1) frequently stands, self-transfers, walks around unsupervised. This form documents that R1 was one on one with the nurse while passing medications.

On 3/13/24 at 10:30am, V7 (Registered Nurse/Minimum Data Set Nurse) stated that R1's base line care plan did not have fall interventions put into place. V7 verified that R1 should have had a completed care plan at the time of her fall.

On 3/13/24 at 2:20pm, V1 (Administrator) stated that R1 had a history of falls prior to admission to the facility. V1 stated that the facility does not have the staff to do one on one care.

On 3/13/24 at 2:50pm, V4 (LPN) stated that R1

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was anxious and kept trying to stand up. V4 stated that the staff could not get their jobs done, so she took R1 with her during medication pass. V4 stated that she entered a room to give medicine then heard a "Ah". V4 stated she went to check on R1 and she was on the floor. V4 stated that R1 was rubbing her knees but did not show signs or symptoms of pain. V4 verified that R1 had adverse behaviors often. V4 verified that R1 was out of sight for only a minute and fell. V4 stated that R1 did not get out of bed after returning from the hospital.

The facility's Care Plans policy, reviewed 03/13/24, documents that the resident care plan is initiated at the time of admission. This form documents that the care plan will include the following information but not limited: needs, concerns or problems identified during initial assessment of the resident.

The facility's Falls and Incident Reporting policy, modified 10/31/23, documents that a Fall risk Assessment 2.0 Form is to be completed as soon as possible and practicable, within 24-48 hours as practicable, when a resident has sustained a fall. This form also documents that the resident's care plan is reviewed and revised as indicated. Approaches will be implemented for ongoing evaluation of interventions will be done on a resident individualized basis.

"A"