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	IL6010466	A. BUILDING: _____ B. WING _____	C 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF LAKE STOREY	1250 WEST CARL SANDBURG DRIVE GALESBURG, IL 61401

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S 000	Initial Comments Complaint Investiagtion 2422630/IL171527	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.2420j) 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 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. Section 300.2420 Equipment and Supplies j) There shall be a sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures. These requirements were not met as evidenced by: Based on interview and record review the facility failed to ensure safe positioning in bed was maintained during incontinence care and failed to obtain an air mattress and safety devices for one of three residents (R4) reviewed for falls in the sample of 12. These failures resulted in R4 falling from bed, hitting head on floor, and obtaining a hematoma to her forehead. Findings include: The facility's Fall Prevention Program, dated 2023, documents, "Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. A fall is an event in which an individual	S9999		

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unintentionally comes to rest on the ground, floor or other level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere."

The facility's Safe Resident Handling/Transfers policy and procedure, dated 2023, documents, "It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines."

The facility's Turning and Repositioning policy and procedure, dated 2023, documents, "It is our policy to implement turning and repositioning as part of our systematic approach to pressure injury prevention and management. This policy establishes responsibilities and protocols for turning and repositioning." "Turning and repositioning is a primary responsibility of nursing assistants. However, all nursing staff are expected to assist with turning and repositioning." "Use the appropriate number of staff to perform the tasks safely." "Utilize positioning devices as needed to maintain posture."

The facility's Use of Support Surfaces dated 2/1/23, documents, "Support surfaces will be used in accordance with evidence-based practice for residents with or at risk for pressure injuries. Support surface refers to a specialized mattress, mattress overlay, or a chair cushion designed to manage pressure, shear, microclimate, or friction forces on tissue." "Support surfaces will be

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chosen by matching the potential therapeutic benefit with the resident's specific situation. Considerations for utilizing specialized support surfaces: a. Medical condition; b. Size and weight; c. Mobility and activity levels." "d. Due to unique needs and situations of individuals, the guidelines may not be appropriate for use in all circumstances."

The facility's fall log, documents R4 had two un-witnessed falls on 3/10/24 and 3/11/24 and a witnessed fall on 3/25/24.

The current Care Plan for R4, documents R4 returned from hospital visit with a terminal prognosis and diagnosis of acute renal failure, hyperkalemia, urosepsis, and protein calorie malnutrition and on hospice services with a stage 3 coccyx pressure ulcer. R4 is at risk for falls related to deconditioning, gait/balance problems, and psychoactive drug use with history of falls at home and prior nursing facility. R4 had falls on 3/10/24, 3/11/24, and 3/25/24. R4 is receiving hospice services, requires total assist of two staff for turning and repositioning at least every two hours in bed and for toileting. R4's Care Plan was revised with fall intervention added on 3/11/24 to include, "Notify hospice to bring in air mattress with built in bolsters" and on 3/25/24 "Notify hospice (company) to exchange (R4's) bed for a large bed with air mattress with bolsters."

The #499 Un-witnessed fall investigation for R4, dated 3/10/24 at 9:40 pm, documents R4 noted to be laying on floor next to her bed. Nurse assessed. R4 noted to have abrasion to head and discoloration to arm with complaints of head pain. R4 has impaired balance coordination and weakness with poor safety awareness. Resident has a terminal condition and on hospice services.

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S9999	Continued From page 4 Nurse initiated neuros (neurological checks) and R4 was assisted back to bed per mechanical lift. (R4's) Care plan was reviewed and revised to add: Bed to be in lowest locked position with fall mats next to bed." Nurse documented, "(R4) has poor upper body control, tends to lean towards right side while in bed. Requires constant repositioning." The #501 Un-witnessed fall investigation for R4, dated 3/11/24 at 3:00 pm, documents, "Prior fall note exact same incident on 3/10/24." R4 was observed on left side of bed on the floor, lying on her right side, with pillow under face with no injuries. The root cause was documented as poor balance, coordination, weakness, restlessness, and terminal condition. Hospice notified for an air mattress with bolsters. The #505 Witnessed fall investigation for R4, dated 3/25/24 at 10:15 pm, documents V9 LPN (Licensed Practical Nurse) and V10 CNA (Certified Nursing Assistant) repositioned R4 from the far right of the bed to the center of the bed, turned R4 to left side, facing V10 CNA and "while (V10) CNA had (R4) turned towards him (V10 CNA) and (V10) was wiping (R4's) buttocks, (R4's) upper body slid off of air mattress." R4 complained of face and nose pain and rated pain a "5" out of 10 on pain scale. V9 LPN assessed R4 noting 6.0 cm (centimeter) x 5.0 cm hematoma (abnormal collection of blood outside of blood vessel) to middle of forehead and the tip of R4's nose was potentially crooked. The local hospice to order a bariatric air mattress and V2 DON (Director of Nursing) requesting air mattress with bolsters. "Care Plan reviewed and revised to add: Notify hospice (company) to provide a larger bed, air mattress with bolsters." The Post Fall Evaluation for R4, dated 3/26/24 at 2:54 am,	S9999		

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documents reason for R4's fall as "slipped out of air mattress, needs a bigger bed" and injury as "hematoma to forehead." "Contributing Factors Noted: slippery bed/air mattress." R4 verbalized pain of "4" out of 10 on pain scale with "grimacing," "withdrawing" and "shows non-verbal signs of pain."

On 4/5/24 at 3:24 pm, V18 LPN/Licensed Practical Nurse stated she was called down to R4's room on 3/10/24 because R4 was on the floor. R4 was found on the floor next to her bed, face down with an abrasion to her forehead. R4 was not able to move her legs but could move her upper body some, could move her arms, had poor control and would lean to the right. R4 had an air mattress, that seemed a bit unleveled, floor mats on the floor, and the bed was kept as low as it would go but was not a low to the floor bed. V18 LPN stated R4 was not morbidly obese but was wide and round and needed a bigger bed and was requested from the hospice company. R4's bed and nightstand were also moved because "it looked like (R4) may have hit her head on the nightstand." V18 LPN stated she called and requested the hospice company to come to the facility to see R4 and after coming they just said to monitor R4 and never brought a bigger mattress.

On 4/3/24 at 2:45 pm, V5 LPN stated R4 returned from a hospital visit on hospice services due to kidney and cardiac issues and was actively dying prior to her last fall. V5 LPN stated on the morning of 3/26/24, during shift report, V9 LPN reported R4 had fallen out of bed during the night, while cares were being provided, and V5 LPN only recalls seeing bruising to R4's forehead but nothing abnormal to R4's face. V5 LPN stated R4 was restless at times but mostly at nighttime. V5

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S9999	Continued From page 6 LPN stated the air mattresses are slick and R4 wore silky nightgowns which probably didn't help. V5 LPN stated R4 had previous falls on 3/10/24 and 3/11/24 and on 3/11/24 V5 LPN requested the hospice company bring a bariatric air mattress and bolsters for R4's bed so there was more room for R4, but they never brought anything. On 4/5/24 at 12:53 pm, V10 CNA/Certified Nursing Assistant stated on 3/25/24 he and V9 LPN went in to clean up R4 and care for R4's coccyx wound treatment. V10 CNA stated R4 had to be moved to the middle of the bed before starting due to R4 leaning to the right side. V10 CNA stated, "We rolled R4 towards me, and V9 LPN started cleaning R4 up because R4 had a bowel movement." V10 CNA stated both he and V9 LPN were holding onto R4 and both trying to clean R4 up and R4 "just slid off the bed." V10 CNA stated "(R4) had an air mattress and had already fallen numerous times before. In my opinion air mattresses are not safe for all residents." V10 CNA stated there were no bolsters on R4's air mattress and "(R4) should have had a bigger bed to start with." R4 was actively dying prior to the fall and wasn't able to help, "she just rolled right out." V10 CNA stated, "I told them on my witness statement that I told V9 LPN that (R4) needed a bigger bed and that I didn't think the air mattress was safe because (R4) had prior falls." V10 CNA stated, "The only thing I can think of is that we could have gotten another person to help but we only had to have two before." On 4/5/24 at 4:20 pm, V9 LPN stated she and V10 CNA went in to do (R4's) coccyx wound treatment on 3/25/24 but R4 had a bowel movement and needed cleaned up first. V9 LPN	S9999		

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stated R4 had to be moved to the middle of the bed because R4 tended to lean to her right. V9 LPN stated R4 was rolled onto her left side facing V10 CNA. V10 CNA was standing at about R4's pelvis area holding R4 at the hip area with one hand and was wiping R4's buttock with his other hand. V9 LPN stated she was on the back side of R4 and had hand on R4's shoulder or hip area and at times she and V10 CNA were both wiping stool from R4's buttocks at the same time. V9 LPN stated R4's bed was in the up position while they were giving care and R4's "head and top half of body just slid right off the bed." V9 LPN stated they tried to stop R4 from falling but couldn't, "it happened so fast." V9 LPN stated R4's body fell onto the fall mat but R4's head hit the floor, causing "a goose egg on her forehead and her nose did look a little crooked at the tip but I honestly didn't know if it was already like that or not." V9 LPN stated, "(R4) has fallen other times because of the air mattress" and R4 "needed a bigger bed because (R4) was very round and filled the mattress she had." V9 LPN stated the hospice company was asked to bring a bigger mattress and bolsters for R4 but never brought them. V9 LPN stated she did notify the hospice company who told her to just put ice wherever R4 was hurting. V9 LPN stated, "A bigger bed or bolsters probably would have helped prevent (R4) from falling." V9 LPN also confirmed that if V10 CNA had just been holding her and not wiping (R4), might have had better control of R4 and prevented R4's fall.

On 4/5/24 at 2:23 pm, V2 DON/Director of Nursing stated generally during incontinence care of residents requiring two assist; the staff member the resident is facing holds and secures the residents position while the staff member facing the residents back side does the

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S9999	Continued From page 8 incontinence care. V2 DON stated it was reported that V9 LPN and V10 CNA were in the room providing cares for R4 and R4 fell out of the bed. V9 LPN and V10 CNA were cleaning R4 up and preparing R4 for the wound treatment. V10 CNA tried to stop R4 but R4 was top heavy and fell to the floor. V2 DON stated the facility had been trying to get a larger air mattress or bolsters from the hospice company for some time. V2 DON stated a bariatric air mattress and bolsters were requested from the hospice company multiple times. V2 DON stated, "We went back and forth with (hospice company) and evidently they have requirements based on the resident's condition in order to provide one." V2 DON confirmed not having a larger air mattress or bolsters may have "potentially" contributed to R4's fall and that V10 CNA should have had both hands on R4 securing R4's position on the bed. On 4/5/24 at 4:27 pm, V1 Administrator stated the facility was having trouble getting a bigger air mattress and bolsters from the hospice company, who said they weren't allowed to deliver one due to their rules and the cuts that were made. V1 Administrator stated she called the facility's corporate office who called the hospice company's corporate office and they finally agreed they would deliver one but would be a week or so. V1 Administrator stated R4 ended up passing before the hospice company delivered anything to the facility. V1 Administrator confirmed that V10 CNA should have had both hands holding onto R4 while V9 LPN performed the incontinence care, and she would make sure the nursing staff was educated. (B)	S9999		