STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010128	A. BUILDING: _____ B. WING _____	C 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-MOUNT ZION	1225 WOODLAND DRIVE MOUNT ZION, IL 62549

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S 000	Initial Comments Complaint Investigation #2061018/IL119958	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 d)3) 300.1210 d)6) 300.1220 b)3) 300.3240 a) 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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see that each resident receives adequate supervision and assistance to prevent accidents.

Section 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. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These regulations are not met as evidenced by:

Based on interview and record review, the facility failed to develop and implement targeted resident specific interventions to address increased agitation and fall prevention for one resident (R1) reviewed for falls in a sample list of three residents. R1 experienced expected situational agitation and sustained a fall resulting in a right hip fracture and subsequent surgical Right Hip Replacement.

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Findings Include:

R1's face sheet, printed 2/11/20, includes the following diagnoses: Chronic Obstructive Pulmonary Disease, Cerebral Palsy, Dementia With Behavioral Disturbance, Delusional Disorder, Restlessness and Agitation. R1's Minimum Data Set (MDS), dated 1/13/20, documents R1 is severely cognitively impaired and requires extensive assistance of two or more staff members to transfer/toilet. This MDS also documents R1's balance is "not steady only able to (be) stabilized with staff assistance."

R1's fall risk assessments, dated 11/6/19, 1/6/20, and 1/25/20, document R1 is at high risk for falls and has had prior falls. These assessments document that R1's gait is impaired (difficulty rising from chair, keeps head down when walking, grasps furniture, person or aid when ambulating). The assessments document that R1 overestimates or forgets limits with regard to ambulating safely. None of these assessments document R1's situational agitation and/or it's potential to contribute to falls.

R1's Physical Therapy Assessment, dated 1/6/20, documents, "Due to physical impairments and associated functional deficits, (R1) is at risk for falls."

R1's Progress Note, dated 1/25/20 at 5:20PM, by V12, Registered Nurse (RN), documents, " Observed (R1) standing from wheel chair, sensor alarm sounding, writer on phone, other nurse (V15, Licensed Practical Nurse) at other desk started running. (R1) going to floor, unable to reach in time to prevent. Went to floor on back, hit back of head on floor, noted wasn't extending Right leg straight, (R1) continues to complain of

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pain Right groin." Later documentation by V12 on 1/25/20 documents that R1 was sent to the emergency room per ambulance. R1's hospital discharge summary by V18, Medical Doctor, dated 2/5/20, documents, "Acute impacted Right Femoral Neck Fracture Hip Surgery 1/28/20."

R1's 1-28-20 Care Plan documents an entry initiated 9/16/15 stating, "(R1) at risk for falls Related To Confusion , Poor communication/comprehension, Psychoactive drug use and increased weakness." R1's fall interventions are documented to include: "be sure (R1's) call light is within reach and encourage (R1) to use it for assistance as needed, (R1) encouraged to wear shoes for all transfers and ambulation, (R1) needs a safe environment with even floors free from spills and/or clutter; adequate, glare free light; a working and reachable call light; handrails on walls, personal items within reach, ensure (R1) is wearing non-skid shoes when ambulating, monitor for potential side effects of psychotropic drugs, non skid strips in front of bed and chair, remind (R1) to use call light and not get up alone, staff to be conscious of when (R1) chooses to get up and go to (R1's) bathroom to do (R1's) morning face washing routine." There are four interventions related specifically to safety considerations to be implemented by R1's spouse and family when alone with R1.

R1's 1-28-20 Care Plan does not address R1's situational agitation and/or it's potential to contribute to falls.

On 2/10/20 at 1:05PM, V15, Licensed Practical Nurse (LPN), stated, "After (R1's) (Visitor) left at around 3:30PM on 1/25/20, (R1) was calling out like (R1) always does. (R1) always asks where is

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my family and tells us (R1) needs to go home. (R1) had tried to get up unassisted several times before (R1) fell. When a resident needs constant attention, we sit them in wheelchairs outside their rooms in the hall. There were two CNAs on the hall but when (R1) fell both CNA's were busy in resident rooms. (V12) and I were at the desk. (V12) was on the phone. I heard (R1's) chair alarm, but by the time I got to (R1) had fallen."

On 2/11/20 at 9:45AM, V14, Certified Nurse's Aide (CNA), stated, "(V13) and I assigned to South hall on 1/25/20. I was in a resident room feeding when (R1) fell. (R1) was on the floor by the time I came out. (R1) gets real angry when (visitor) leaves. Then (R1) will try to get out of the wheelchair. (R1) used to work word search puzzles and that would keep (R1's) mind occupied but because of (R1's) dementia (R1) gets even more angry when (R1) can't find a word. We have to keep a constant eye on (R1)."

On 2/11/20 at 10:48AM, V12, Registered Nurse (RN), stated, "I was talking on the phone V15, Licensed Practical Nurse (LPN) was at the other desk charting. (R1) was in a wheelchair sitting outside (R1's) room. The two CNAs who were assigned to the hall were in resident rooms giving care. (R1) has a habit of becoming upset when (visitor) leaves. (R1) will ask where is my family. I need to go home with my family. Then she will get up and try to walk unassisted. R1 had tried to get up several times after (visitor) left. We redirect (R1) and try to distract (R1). We used to give (R1) word search puzzles, but that only gets (R1) more upset now when (R1) can't find a word. We had several residents in the hall who needed to be supervised. I guess we could have put (R1) closer to the desk so we might have prevented (R1) from falling."

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On 2/11/20 at 1:30PM, V13, Certified Nurse's Aide (CNA), stated, "I remember the evening (R1) fell (1/25/20). I was in a room giving a bed bath. It was Saturday. We were really busy that weekend. We had several residents with the stomach flu. By the time I came out in the hall (R1) had already fallen. (R1) gets anxious when (visitor) leaves and tries to get out of wheelchair to go home and find family. (R1) had tried to get up a few times that day before (R1) fell. When (R1) does that we just remind (R1) that her (visitor) will come back."

On 2/11/20 at 1:30 PM, (V3) Restorative Nurse stated, "Yes we are all aware that (R1) gets very agitated when her husband leaves. (R1) wants to go with him and will try to get up. (R1) constantly asks where is my family? I need to get home with my family. (R1) has a care plan for falls." When asked where this behavior is documented on R1's care plans, V3 stated "We just all know her."

On 2/11/20 at 2:00PM, V17, Physical Therapy Assistant, stated, "We did evaluate (R1) on 1/6/20 after (R1) returned from an extended hospital stay. We worked with (R1) to help regain strength. (R1) was not safe for independent ambulation and basically has no safety awareness. I would expect that when (R1) is agitated especially after (Visitor) leaves, the staff would try to distract (R1) with puzzles, books, and try to talk (R1) down."

On 2/11/20 at 1:15PM, V5, Medical Director, and R1's primary care provider stated, "I would say that the fall (R1) experienced (1/25/20) is likely the mechanism which caused (R1's) hip fracture."

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