| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | IL6010128 | A. BUILDING: _____ B. WING _____ | C 08/31/2020 |

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| HERITAGE HEALTH-MOUNT ZION | 1225 WOODLAND DRIVE MOUNT ZION, IL 62549 |

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| S 000 | Initial Comments<br><br>Complaint Investigation #2064212/IL123425 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.1210 b)<br>300.1210 d)6)<br>300.1220 b)3)<br>300.3240 a)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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.<br>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:<br>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.<br><br>Section 300.1220 Supervision of Nursing Services<br>b) The DON shall supervise and oversee the nursing services of the facility, including: | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br><br>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.<br><br>Section 300.3240 Abuse and Neglect<br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br><br>These regulations are not met as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to assess underlying behaviors leading to falls, and failed to develop and initiate individualized, resident centered fall prevention interventions for two residents (R1 and R3). R1 and R3 are two of three residents reviewed for falls with injury in a sample list of three residents. This failure resulted in a fall for R1 causing a broken left hip with resulting pain. This failure also resulted in a head injury from a fall and a laceration requiring five stitches for R3.<br><br>Findings Include:<br><br>1. R1's Care Plan, reviewed 7/14/20, includes the following diagnoses: Stage three Dementia, Obsessive Compulsive Disorder, and Severe Delusional Disorder. | S9999 | | |

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| S9999 | Continued From page 2<br><br>R1's Minimum Data Set (MDS), dated 7/15/20, documents R1 is severely cognitively impaired and R1's balance is "not steady. Only able to stabilize with human assistance."<br><br>R1's Care Plan, documented as reviewed 7/14/20, states: I am at risk for falls related to Confusion , Poor communication/comprehension, Psychoactive drug use and increased weakness. Date Initiated: 09/16/2015.<br><br>R1's Progress Note, dated 1/25/20, documents that R1 sustained a fall with a right hip fracture.<br><br>On 3/4/20 R1's Care Plan documents a problem: "(R1 has) a behavior problem yells out statements: help me; Where is my family; her husbands name." Though some generic interventions are documented on R1's care plan, a resident specific plan of interventions when this behavior occurs is not documented.<br><br>On 5/12/20 at 3:45 PM, V3, Licensed Practical Nurse (LPN) documented in R1's progress note, "Resident yelling out help me, help me I have to go to the bathroom. Where's my husband, I want to go home."<br><br>R1's occurrence report by V9, Licensed Practical Nurse (LPN), dated 5/12/20 at 5:01 PM, documents "(R1) observed on floor in room (R1) assessed. Complains of left hip pain with external rotation of leg. Medical Doctor and Power of Attorney notified. New order received send to ER (emergency room) for evaluation and treatment."<br><br>R1's hospital discharge Summary, dated 5/18/20, documents, "Hip Fracture noted 5/12/20." | S9999 | | |

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| S9999 | Continued From page 3<br><br>On 8/24/20 at 12:50PM, V5, Licensed Practical Nurse (LPN), documented a progress note, "(R1) continues asking and yelling for her: husband, (Daughter) where is my father, get out of here, you idiot." This behavior of calling for family members is documented in progress notes by various staff members 8/18/20, 8/21/20. There are frequent progress notes by various staff dating back over a year documenting R1's behavior of searching for husband and daughter and thinking she needs to go home. These behaviors frequently are documented mid-afternoon to evening.<br><br>On 8/25/20 at 11:15AM, R1 was sitting alone in her room and appeared to be watching television. The curtain was half closed, and R1 could not be visualized without entering the room. At 1:48PM, R1 was wheeling down South Hall. There were no staff in the area monitoring R1.<br><br>On 8/26/20 at 2:46PM, V8, Certified Nurse's Aide (CNA), stated, "(R1) was my resident the night she fell (5/12/20). (R1) was in her room and we heard the alarm. We rushed in and (R1) had fallen into her closet. (R1) seemed to have a lot of pain. The nurse took over from there. (R1) always calls about for her husband or daughter. She will not calm down until she sees or talks to them. She had been yelling for her husband before she fell. I guess she gets up to try to find him. (R1) pretty persistently asks for him."<br><br>On 8/26/20 at 3:07PM, V4, Registered Nurse (RN), Care Plan Coordinator, stated, "I know (R1) does have some behaviors. I'm not sure what the behaviors are. I think we tried a lap buddy and (R1) was able to take it off easily and so we switched to a seat belt." | S9999 | | |

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| S9999 | Continued From page 4<br><br>On 3/24/20 at 3:15PM, V3, Restorative Nurse, documented that the thought of discontinuing lap buddy and starting with alarmed seat belt for safety was to try and decrease agitation episodes.<br><br>On 8/26/20 at 3:15PM,when asked if the interdisciplinary team had discussed a behavioral program concentrated on R1's behavior of frequently calling out for her family, V3 stated, "I don't take care of the behavioral programs. I'm not sure who does."<br><br>2. R3's Diagnoses Sheet, dated December 5, 2019 and reviewed on May 28, 2020, documents a diagnosis of Dementia, Congestive Heart Failure, Weakness, fracture of 2nd Cervical Vertebra, Macular Degeneration and Dysphagia.<br><br>R3's Minimum Data Set, dated May 27, 2020, documents R3 as severely cognitively impaired.<br><br>R3's Care Plan, dated April 4, 2020, documents dementia interventions including monitor, reminisce, and use task sequencing with R3.<br><br>R3's Behavior Documentation Record of June 2020, documents R3 yelling/screaming on 26 separate occasions, with only documented interventions as one to one or offering food.<br><br>R3's Progress Note, dated June 5, 2020, documents, "(R3) crashing her wheel chair into medication cart, removing med cups, throwing all over floor." "Non-pharmacological intervention of one to one, explained to resident she may end up causing injuries to self or others with this action, writer able to redirect resident." | S9999 | | |

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| S9999 | Continued From page 5<br><br>R3's Fall Documentation of June 9, 2020, 6:00 PM, documents that V6, Certified Nursing Assistant, witnessed R3 throw herself out of wheelchair in hallway. Fall resulted in a skin tear and bump on head.<br><br>R3's Behavior Documentation Record of July 2020 documents 13 occasions of R3 yelling/screaming, with only behavioral interventions as one to one, offering food or toileting.<br><br>R3's Fall Documentation Record of July 7, 2020, 10:30 AM, documents R3 fell trying to get out of bed.<br><br>R3's Care Plan, dated August 2020, documents dementia interventions including monitor, reminisce and use task sequencing with R3.<br><br>R3's Behavior Documentation Record of August 2020, documents 11 occasions of R3 yelling/screaming with the only behavioral intervention as one to one, offering food or toileting.<br><br>R3's Fall Documentation of August 3, 2020 at 7:00 AM, documents R3 fell in room. Resulted in a head laceration and 6 stitches.<br><br>R3's Fall Documentation of August 23, 2020 at 6:12 PM, documents R3 fell in room out of bed.<br><br>On 8/27/2020 at 9:18 AM, V2 stated that the Restorative Nurse documents on all falls and recommends interventions for implementation.<br><br>On 8/27/2020 at 9:21 AM, V3, Restorative Nurse, was asked what type of dementia training V3 had been given that would relate to R3's falls, "I'm not | S9999 | | |

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sure."

On 8/27/20 at 10:10 AM, V6, Certified Nursing Assistant, was asked about V3's falls and behaviors. V6 stated, "(R3)screams a lot in her room and wants us in there a lot. She tries to get out of bed and won't use her call light." When asked about R3's cognition, V6 confirmed that R3 is confused. When asked about what R3 does when her alarms go off, "(R3) yells." "If we don't come in when (R3) wants us, (R3) tries to get out of bed."

On 8/27/20 at 9:48 AM, V2 was asked about R'3s fall interventions with respect to R3's behaviors. V2 confirmed that no specific interventions were made related to R3's behaviors. V2 confirmed that R3 is in a room that is not close to the nurse station, "We don't have one across from the station currently available." V2 stated "(R3) falls because she is confused and thinks that she can transfer herself. It would help if someone were with her all of the time, but we don't do one to one care."

The facility's policy "Fall Assessment and Management", revised 4/2019, states, "It is the policy to assess each resident's fall risk on admission, quarterly,and with each fall. This will help facilitate an interdisciplinary approach for care planning to appropriately monitor and assess and ultimately reduce injury risk. Factors related to falls will be addressed and care planned." This policy also states "F. Interventions will be based on fall risk assessment and the circumstances surrounding the risk for injury or actual injury or fall. Some examples may be: Falls related to gait or balance deficit, Falls related to confusion, Falls related to sensory/perceptual problems, Falls related to poor judgement or

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| S9999 | Continued From page 7<br>knowledge deficit."<br><br>(B) | S9999 | | |