STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007868	A. BUILDING: _____ B. WING _____	C 11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT SOUTH HOLLAND, THE	16300 WAUSAU STREET SOUTH HOLLAND, IL 60473

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S 000	Initial Comments Complaint Investigation #1998294/IL117415	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 a) 300.1210 b) 300.1210 d)6) 300.3240 a) 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 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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:
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 300.3240 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 have interventions in place for a resident with known syncope episodes, and failed to keep the high fall risk resident in a highly visualized area during awake hours for one (R8) of four residents reviewed for resident injury in regards to falls in a total sample of eight residents. This failure resulted in R8 receiving a total or 11 sutures to lacerations sustained to the forehead and lower lip, and broken dentures.

Findings Include:

R8 is an 89 year old with the following diagnosis: repeated falls, syncope and collapse, muscle weakness, and rhabdomyolysis. R8 admitted to the facility on 9/26/19.

An Admission note on 9/26/19 documents R8 admitted for fall from home and requires

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assistance with transfers and care. A Nurse Practitioner note, dated 10/10/19, documents R8 examined and occasionally reports some dizziness, but there has been an improvement. A Daily Skilled note, dated 10/14/19, documents R8 requires supervision for safety. A Physician Note, dated 10/14/19, documents R8 denied dizziness, but reported lightheadedness with position changes, especially going form sit to stand. A Nurse Practitioner note, dated 10/23/19, documents R8 still needs supervision and a wheelchair for safe mobility. R8 is not a candidate to discharge without 24/7 supervision due to cognitive and functional issues. A Nursing note, dated 10/26/19 at 6:10AM, documents R8 noted sitting on the side of the bed and just finished using urinal. A Nursing note on 10/26/19 at 7:35AM documents the nurse was called to R8's room by the CNA at 6:50AM. R8 noted lying face down with blood on the floor. On assessment, a laceration to the forehead and a cut to the lower lip was noted. Per the CNA, R8 observed standing by the side of the bed and said, " I feel dizzy," and then slumped over and fell. 911 called, and R8 taken to the hospital for an evaluation.

The Fall Risk Evaluation dated, 9/26/19, documents R8 with a score of 9, and on 10/26/19, documents R8 with a score of 15 (a score of 5 or higher is considered a high fall risk). The Incident Report, dated 10/31/19, documents R8 attempted to stand up unassisted and lost balance and fell to the floor.

The Care Plan, dated 9/27/19, documents R8 is a risk for falls with interventions focusing on proper footwear and anticipating/meeting resident's needs. The Care Plan does not address resident's syncope, lack of safety awareness,

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impulsivity, or need for increased supervision.

The Hospital Records, dated 10/26/19, document R8 reported falling while trying to get out of the wheelchair after feeling dizzy. Per the ambulance, R8 did lose consciousness at the time of the fall. R8 noted with forehead laceration and lower lip laceration, with broken teeth to dentures. Nine sutures were needed for the forehead laceration, and two sutures were needed for the lower lip laceration. R8 admitted to the hospital for observation due to being unable to recognize family members, which is not R8 ' s baseline.

On 11/12/19 at 2:49PM, V8 (CNA) stated, "I was in the isolation room across the hall finishing up care with that resident for the morning. I was taking off my isolation gear when I saw R8 stand up in R8's room. I tried to ask R8 hey what are you doing and sit back down. R8 said I feel dizzy and then R8 fell. I ran and told the nurse and when we came in he was bleeding on his forehead and mouth. R8 said R8 didn't remember what happened. R8 just fell when R8 was standing there. I never saw R8 take any steps. I don't know if he passed out. He just fell. No, he never said what he was trying to do. R8 did try to get up alone often so we would make sure we would check on R8 when we did our rounds. Yes, R8 was a high fall risk. R8 needed assistance with almost everything. I don't remember what interventions R8 had in place for falls."

On 11/13/19 at 11:41AM, V9 (Nurse Practitioner) stated, "R8 was admitted for a debilitating fall from a syncopable episode and spending hours on the floor. I know R8 was on the second floor and that is where residents that need to be

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watched more closely for falls are placed at that facility. I know R8 was a high fall risk based on R8's confusion and ataxia, and R8 wasn't progressing that much in therapy. If you look at one of my last notes on R8 speaking on discharge I wrote that R8 will require 24 hour supervision at home because of R8's falls and because of R8's cognition. Yes, R8 did have a history of syncopable episodes but I don't know what the facility should have done more to keep R8 safer. That is a decision that is up to them. All I can say was that R8 was on the second floor, and R8 shouldn't having been getting out of bed without assistance."

On 11/13/19 at 11:53AM, V10 (Nurse Consultant) stated, "R8 was getting physical and occupational therapy for having a fall at home and being on the floor for a prolonged period of time. R8 lived alone before R8 got here and that was R8's goal to go back home. R8 was extensive assistance just moving side to side in the bed. Even walking with the staff wasn't done, being it was deemed as not being safe. R8 was only allowed to do walking with therapy. R8 did want to exert independence and when R8 got here R8 probably didn't want to lose that. The interventions are individualized and generally if they have a history of falls we put that in the care plan right away. It is always individualized for that specific person's needs. We have a general fall form and it starts at admission with the assessment for falls. R8 scored a 9 and a 5 is considered a high risk so R8 was off the charts. R8 was always escorted to the restroom and are always in high visual areas during awake hours. R8 was also in a restorative program to promote independence. The fall care plan focused on his shoes and brakes being locked on the bed and wheelchair. The appropriate shoe wear was focused on

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because he was in the walking program both PT and restorative. We didn't put anything in R8's care plan about the syncope because that is not something you can care plan. R8's BIMS score was a 14 so R8 was way cognitively intact. I think this fall was just a moment of impulsivity. Based on the documentation, he had decreased safety awareness. We had several meetings with the family and they continued to say they wanted to go home alone but it was decided he couldn't do that. The only thing that we could have done is do rounds on R8 to keep R8 safe. In R8's note it, says that R8 requires supervision for safety. We round on residents like this every hour. The nurse does one hour and the CNA does the next hour."

On 11/13/19 at 12:44PM, V11 (RN) stated, "I remember I was in R8's room that morning at around 6 to do his vital signs, and R8 was fine. R8 used the urinal and was sitting on R8's bed. I went back to the nurse's station to finish up and chat with the other nurses coming on for the day when the CNA yelled for me down the hall. I came down to R8's room and saw R8 lying on the floor face down, and R8 was bleeding. When I asked R8 what R8 was doing R8 told me R8 doesn't remember what happened. Yes, he was a high fall risk. We try to consider all residents high fall risks to keep them safe. No, R8 shouldn't be allowed to get up alone because R8 needs help getting up. R8 wasn't a high priority resident to get up out of bed when I saw R8 the first time so I left R8 there. Thinking back now, I should have laid R8 back down in the bed until R8 was going to get up on the day shift."

(B)