STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000574	A. BUILDING: _____ B. WING _____	C 06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF FOX VALLEY,THE	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

(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 #1973661/IL112360	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 c) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 observation, interview, and record review, the facility failed to ensure two staff members assisted residents with bed mobility and toilet use. This failure resulted in R1 falling out of bed and sustaining bilateral femur fractures.

This applies to 2 of 3 residents (R1 and R2) reviewed for falls in a total sample of 7 residents.

The findings include:

1. According to the Electronic Health Record (EHR), R1 had diagnoses including: fracture of the lower end of right and left femur, fracture of

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right tibia (05/10/2019), schizoaffective disorder, bacteremia, peripheral vascular disease, bilateral below the knee amputation, diabetes, glaucoma, cardiomyopathy, renal dialysis dependent, end stage renal disease, anxiety disorder.

The Minimum Data Set (MDS) dated 03/21/2019, showed R1 needed extensive assistance of two people for bed mobility and bathing, and was totally dependent on two people for transfers and toilet use. The MDS showed R1 had impairment of the upper extremities on one side, and impairment of the lower extremities bilaterally. The MDS showed R1 weighed 182 pounds. R1 had a Brief Interview for Mental Status (BIMS) of 15 out of 15 possible points, indicating (R1's) cognition was intact.

A care plan showed R1 had Activities of Daily Living (ADL) self-care deficit related to limited mobility, with interventions including needing extensive assistance of two staff members for toileting and bed mobility.

A Hospital X-ray report dated 05/10/2019, shows R1 had a fracture of the right distal femur, likely a right proximal tibial fracture, and a left distal femur fracture with slight posterior displacement and mild impaction along the medial aspect.

On 05/23/2019 at 11:00 AM, R1 said on 05/10/2019, V5, Certified Nursing Assistant (CNA), had been "changing (R1) and was changing (R1's) sheets." V5 was standing on R1's right side as R1 was leaning to R1's right side, when V5 told R1 to roll over to the left side. R1's right hand was slightly contractured. R1 said R1 had very little use of R1's right hand to grasp anything, and could not hold the side rail very well with R1's right hand. R1 said R1 had to roll over a

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bump in the bed. "The bump was the sheets and everything rolled up behind (R1's) back." Rolling onto R1's left side would have placed R1's left dominant hand underneath R1's side, leaving R1's right hand with limited range of motion free, but be unable to grasp the side rail with R1's right hand. R1 said R1 must have been positioned in bed closer to the footboard than R1 thought, because when R1 rolled over, R1 went right out of the bed without hitting the side rail. R1 said there was a partial side rail, but it didn't help because R1 was positioned lower than where the bed rail was at. R1 said when R1 fell out of bed, R1 hit the floor, first with R1's knees, then with the hips. R1 said the fall caused both femurs to be fractured. R1 said R1 was able to help turn R1 in bed, but there should be another person to be on each side so R1 wouldn't roll out of bed. R1 said prior to the fall there was usually two people to assist when turning R1 in bed, however, there were not always two people to assist on the weekends or the night shift, when there would only be one person. R1 said the bed was positioned pretty high; it was not in the low position when R1 fell. R1 said since the fall R1 has needed to take Norco for the pain, and also alprazolam, but R1 continued to have leg muscle "contractions" (spasms) which were painful. R1 said the fall had limited R1's ability to help turn in bed.

On 05/23/2019 at 1:06 PM, R1 said V5 had started to walk around the bed to the other side and "(V5) probably didn't think (R1) would roll as fast as (R1) did." R1 said V5 definitely told R1 to roll, because R1 wouldn't have rolled unless V5 told R1 to. R1 said some of the CNAs will just say "Let's go" and R1 doesn't know what that means, so R1 will ask them, or wait for them to tell R1 what to do specifically.

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On 05/23/2019 at 1:25 PM, V7, Licensed Practical Nurse (LPN), said R1 always needed to have two people assisting with R1's care. V7 said the CNAs are paired with another CNA during the day shift and the evening shift. V7 said if the CNA needed to assist anyone who required a two person assist, then the CNAs are to find their partner and assist the person. V7 said R1 was alert and oriented to person, place, and time and had never been impulsive. V7 said R1 was a larger person with limited movement, and definitely needed two people to assist R1 with turning in bed, or it would be very dangerous.

On 05/28/2019 at 11:24 AM, V5 said V5 had provided incontinence care to R1 alone, and was in the process of changing R1's bed linens. V5 had prepared and tucked the clean sheets under R1. After preparing the initial tuck, V5 was walking from one side of the bed to the other side of the bed, and R1 rolled over in bed without V5 telling R1 to roll over. V5 said prior to providing care , the head of R1's bed had been elevated so R1 had probably slid in the bed toward the foot of the bed. R1 was positioned more in the center of the bed than toward the head of the bed. V5 said during orientation, V5 had been trained to care for R1 using two people during bed mobility and incontinence care. V5 said this was the first time V5 had cared for R1 independently, and had no knowledge of what assistance R1 needed. V5 said the CNAs can find out the level of care needed by looking in the computer, or in the Kardex binder at the nurses station.

On 05/28/2019 at 10:25 AM, V6, Doctor of Physical Therapy, said R1 had very limited mobility and probably couldn't turn in bed very well without assistance.

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On 05/28/2019 at 11:39 AM, V4, Restorative LPN, said the Kardex that the CNAs use was related to the residents care plans, and are updated when the care plan was updated. V4 said the Kardex binder included a weekly list of the residents and the type of mechanical lift assistance needed; transfer assistance of residents needing two or more people; and bed mobility assistance of two or more people. The Weekly Report dated 05/03/19, prior to R1's fall, shows R1 needed mechanical lift assistance, and bed mobility assistance of two persons. At 12:05 PM, V4 said R1 needed bed mobility lift assistance of two people only to lift R1 up in bed, but R1 was able to turn side to side with one person for R1's other care. V4 said prior to the fall, R1 was able to turn side to side with one person assistance. When asked to show where it documented R1's ability to turn side to side with one person assistance, V4 said it was in the care plan. The care plan history for bed mobility dated 07/20/2017, showed "The resident requires two staff participation for toileting needs." No changes were made to the care plan until 05/10/2019, after R1's fall. The revision made on 05/10/2019 showed, "The resident requires one to two staff participation for toileting needs especially with repositioning towards head of bed. Resident able to help during care by turning from side to side. (R1) able to hold on to side rails for mobility. Discontinued". V4 could not explain why the care plan revision dated 05/10/2019 showing R1 was able to assist with side to side turning with one person, was entered after R1's fall.

On 05/28/2019 at 12:28 PM, V2, Director of Nursing (DON), and V3, Assistant Director of Nursing (ADON), stated after the fall R1 needed two person assistance for bed mobility and

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toileting, but prior to the fall R1 was able to be turned in bed and be toileted with one person assistance. When asked where it showed R1 was able to turn side to side with one person assistance, they said it showed it in the care plan. V2 and V3 also said therapy felt she could move side to side on R1's own, and would provide the therapy discharge summary to show documentation of therapy's recommendation.

The ADL Self Care Performance Deficit Care Plan presented by V2 and V3, with a revision date of 05/23/2019, the entrance date of the investigation, and post fall date of 05/10/2019, included the revision R1 has bilateral BKA (Below Knee Amputation). Resident needs extensive assist of two with repositioning towards head of bed, but able to help reposition self from side to side. Per resident " I can help myself on turning side to side." Uses bilateral siderails for mobility and repositioning.

The Occupational Therapy Discharge Summary provided by the facility did not address R1's Bed Mobility or toileting ability, as they were not evaluated.

A Restorative Quarterly Assessment dated 03/15/2019, showed R1 needed extensive assistance of two people for bed mobility, and was totally dependent on two people for toilet use.

On 06/04/19 at 11:30 AM, V10, MD Orthopedic Surgeon, said V10 had not been given much information regarding (R1) ' s fractures from the facility, other than being told a staff member had been turning (R1) in bed, and was not told R1 fell out of bed. V10 said R1 was already at high risk for fractures, and it wouldn't take much impact or

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injury to cause the fractures. V10 stated, "Yes the fractures were caused by an injury of the fall." According to V10, if R1's fractures don't heal in the next several months, the only option available would be to perform amputations higher above the fracture site.

2. According to the Electronic Health Record (EHR), R2 had diagnoses including: hypertension, depression, insomnia, cerebral infarction, hemiplegia, hemiparesis, fall, diabetes, cerebral infarction, and above knee amputation.

The Quarterly Minimum Data Set (MDS) dated 02/12/2019, showed R2 needed extensive assistance of two people for transfers and toilet use. The MDS showed R2 had impaired range of motion on one side of R2's upper and lower extremities, and was not steady moving on and off the toilet, needing staff assistance to stabilize. R2 had a Brief Interview for Mental Status (BIMS) of 15 out of 15 possible points, indicating (R2's) cognition was intact.

A care plan showed R2 was at high risk for falling related to left hemiplegia and left above knee amputation, with interventions including to always use two staff for safety during transfers and toilet use.

The facility's Incident Log showed R2 had a fall on 04/21/2019.

On 05/28/2019 at 9:53 AM, V8, CNA, said R2 was trying to reach the toilet paper in the bathroom. V8 said the toilet paper was on the left side of the toilet, which was on R2's paralyzed side. V8 said R2 stands with R2's one leg, and holds onto the bar or the wall for transfers. V8

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S9999	Continued From page 8 said V8 was more there to support in helping R2 turn and guide R2 on and off the toilet. V8 said R2 was able to clean R2 up, and get on and off the toilet independently. V8 said V8 was alone with R2 and was usually alone. V8 said V8 would ask R2 if R2 needed more assistance from two staff members. V8 said the Kardex will let us know what kind of assistance the residents need. On 05/28/2019 at 10:25 AM, V6, Doctor of Physical Therapist, said R2 had trouble with pivoting because R2 was more unstable due to R2's left side paralysis. V6 said R2 was very impulsive, and didn't listen all the time. On 05/28/2019 at 12:28 PM, V2, (DON), and V3, (ADON), said R2 needed assistance of two people for toilet use. On 05/23/2019 at 4:04 PM, V2 (DON) said the facility does not have a policy regarding resident transfers, but they follow the resident's individual recommendation on the MDS and care plan for resident transfers. (A)	S9999		