STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007181	A. BUILDING: _____ B. WING _____	C 02/17/2021

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S 000	Initial Comments Complaint investigation 2140862/IL130829	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b)5) 300.1210d)6) 300.1220b)3) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 5)All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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 300.1220 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.	S9999		

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S9999	Continued From page 2 These regulations were not met as evidenced by: Based on interview and record review the facility failed to provide adequate supervision and implement progressive interventions to prevent unsafe ambulation and falls for 1 of 3 residents (R2) reviewed for falls in a sample of 7. This failure resulted in R2 flipping over her (enclosed ambulation device/walker) while ambulating. R2 sustained a laceration to chin, left maxillary sinus fracture, right subdural hematoma, left periorbital hematoma, and left inferior orbital wall fracture requiring hospitalization in the intensive care unit (ICU). Findings include: R2's Quarterly Minimum Data Set (MDS) dated 12/07/2020, documents R2 was admitted on 5/9/2015, has severely impaired decision making skills - never/rarely made decisions, requires extensive assistance of one to transfer, supervision with one person physical assist to walk in room, supervision with set up help to walk in corridor/ locomotion on unit, and uses a walker and wheelchair for mobility devices. R2's current face sheet documents R2 was admitted on 5/9/2015 and has the following diagnoses: Alzheimer's Disease/Dementia, schizoaffective disorder/Bipolar, muscle weakness, lower back pain, other abnormalities of gait and mobility, cognitive communication deficit, artificial knee joint, TIA (transient ischemic attacks) history, CVA (cerebrovascular accident) without resident deficit. R2's Care Plan with focused problem of falls was initiated on 5/23/2015. R2's Care Plan documents "(R2) is risk for falls r/t (related to)	S9999		

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Gait/balance problems. History of falls. Alzheimer Disease. Dementia in other Disease Classified, Elsewhere with Behavior Disturbance. Other Abnormalities of Gait and Mobility Schizoaffective Disorder, Bipolar Type." R2's Care Plan Intervention, initiated on 9/1/2016 documents "(R2) to use (enclosed ambulating device/walker) when ambulating if needed." R2's Care Plan, initiated on 1/17/2017, documents "(R2) uses an (enclosed ambulating device/walker) to enhance her mobility in a safe environment. Restraint released tasked for CNAs q (every) 2 h (hours)." R2's Care Plan Intervention, initiated 6/23/2017, documents "(R2) needs to be in high traffic areas while up in (enclosed ambulating device/walker), d/t (due to) unaware of safety needs. Re-educate caregivers." R2's Care Plan, initiated date 10/3/17, documents "When (R2) is restless in bed, place resident up next to nurse's station." R2's Care Plan intervention, initiated on 4/30/2018 documented "Staff educated to monitor resident to make sure she is not going into other resident rooms."

R2's Progress notes, dated 9/28/2020 at 3:30 PM, document, "Health Status Note: Resident was in the tv room and moving around with (R2's) (enclosed ambulating device/walker) when a wheel became tangled in the cord from the blinds. (R2) and (R2's) (enclosed ambulating device/walker) both fell over. No injuries noted at this time. ROM (range of motion) WNL (within normal limits). Resident did c/o (complain of) L (left) hip and L thumb pain. Rcvd (received) order from (physician) to obtain a STAT x-ray of the L hip and thumb."

R2's Care Plan Interventions, initiated 9/28/20, documented "Ensure window blind cords are not

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S9999	Continued From page 4 touch floor r/t getting caught in wheels resulting tipping (enclosed ambulation device/walker)." On 2/17/21 at 2:34 PM, V2, Director of Nurse's/DON, stated she witnessed R2 fall on 9/28/20. V2 stated R2 was in the TV room. V2 stated there are two entries into the area and V2 was actually just going around to one of the entry ways, when she looked over and saw R2 get caught up in the curtain cord. V2 stated the blinds were up for visitors to see loved ones, so the cord was longer. V2 stated the cord wrapped around the wheel and locked the wheels up. V2 stated R2 went forward and the chair didn't. V2 stated, "I immediately ran to (R2) and assessed (R2) and got orders for x-rays. They came back negative. (R2) just ended up with redness and bruising." Facility occurrence report for R2's fall of 1/11/2021 documents "Facility was evacuated due to gas odor in hallway. While outside in designated area to meet for evacuation, (R2) became tearful, anxious, restless and attempted to ambulate in (R2's) (enclosed ambulating device/walker) without anyone assisting (R2) to assure (R2) didn't tip over her (enclosed ambulating device/walker) since it was uneven ground." On 2/16/2021 at 2:45 PM, V2 stated on 1/11/2021 they had to evacuate the facility due to strong gas smell. V2 stated there was staff assigned to R2 and this staff person was V10, Social Services. V2 stated somebody else needed V10. V2 stated V10 turned for just a second and R2 tried to get up with walker and flipped the walker on the uneven ground. V2 stated, "(V10) was right next to (R2) and just turned (V10's) head for a second. (V10) was doing one on one, but just turned for a second to help somebody else. I told everybody	S9999		

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they don't ever leave (R2) unattended, so I was shocked when happened."

On 2/17/21 at 2:28 PM, V10, Social Services, stated that on 1/11/2021 the day the facility was evacuated for smell of gas, V10's job was to assist south hall during the evacuation. V10 stated in emergencies situations her assignment is always to assist south hall. V10 stated the day of 1/11/2021 V10 was handing out blankets because it was cold and V10 went to check on R2 and gave R2 a blanket. V10 stated, "I gave the blanket to (R2), then I turned and walked a couple steps to another resident. I heard one of the residents say (R2's) name and when I turned around, (R2) was already over in the (enclosed ambulating device/walker) on the ground." V10 stated, "I was not assigned to be 1 on 1 with (R2). To be honest not sure who was assigned, there was no staff around (R2) when I was giving (R2) the blanket. (R2) lived on west hall then, they may have gotten (R2) out then went back for more, but I don't want to speak for anybody else. I turned away and only took couple steps, I assume (R2) went off edge in (R2's) specialized walker. I went right to (R2), covered (R2) with a blanket and then nurses were coming out and I yelled for one of them."

On 2/17/2021 at 4:00 PM, V1, Administrator, and V2, were asked if staff were assigned to R2 to assure R2 would not get injured outside in the specialized walker in emergency situations such as the evacuation on 1/11/2021. V1 stated, "I will be honest with you, no, we didn't have in our emergency plan to assign somebody to (R2). That is something we can look at and see if we need to do for other residents in the future." V1 and V2 were notified that during V10's interview V10 stated she was not assigned to provide

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one-to-one for R2 during the evacuation. V2 stated, "I was told (V10) was the one with (R2) and right next to (R2) when (R2) fell. I was told (V10) had just turned around for a second to help another resident. I was in the building and didn't see what happened." V2 stated when this fall was reviewed our intervention was to assign one staff to R2 from now on if outside.

R2's Care Plan was reviewed and there was no revision to R2's care plan after she fell on 1/11/21 to ensure staff would monitor and provide supervision to R2 if outside. There was no further documentation the facility reassessed R2's (enclosed ambulating device/walker) to ensure she was safe to use.

R2's Progress Notes, dated 1/23/2021 at 5:50 PM, document, "Health Status Note: Resident fell while in (R2's) (enclosed ambulating device/walker) chair at approx. (approximately 5:30 PM). Resident was hung-up on a doorway and standing sideways in (R2's) chair and it tipped over causing a gash under her chin, bruising, and swelling to L(left) orbital, and a bloody nose. Resident was sent to (the local hospital) as a precaution. POA (power of attorney), D.O.N (Director of Nursing) notified via phone, PCP (Primary Care Physician) notified via fax. All needed documentation sent with."

R2's Progress notes, dated 1/23/2021 at 7:16 PM, document a Situation, Background, Assessment, Recommendation (SBAR) "The resident is experiencing a change in condition. See SBAR assessment for further information and family/physician notification. The change in condition the resident is currently experiencing is Resident fell onto L (left) side while in (specialized)-chair. Sustained injuries and sent to

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S9999	Continued From page 7 (local hospital) ER (Emergency Room) for evaluation. Resident has been more restless, wandering, and anxious since being moved to North hall for Isolation precautions r/t (related to) recent hospitalization. Attempts to reassure and redirect have been ineffective today." R2's Hospital Records, dated 1/23/2021, documents, "Patient was admitted to (this local hospital) as a category 2 trauma following a fall from wheelchair nursing home. At that time show large periorbital hematoma without loss of consciousness. Workup revealed subdural hematoma." The Hospital History and Physical documented "Right subdural hematoma, Left periorbital hematoma, Left maxillary sinus fracture, Left inferior orbital wall fracture." On 2/10/2021 at 9:52 AM, V4, R2's son, stated that V5, Licensed Practical Nurse/LPN, contacted him regarding R2's fall and notified him she would be going to the hospital for evaluation. V4 stated "My brother went to the hospital the next day to see (R2) and sent me pictures and texts. My brother said it was horrific how bad (R2) looked and sent me pictures. When I saw the pictures, it was horrific, it looked like (R2) had been in the ring with (a professional boxer). Both eyes were bruised and swollen closed, the bruises were a deep purple, (R2) had 2 fractures of the left eye and a brain bleed. (R2)'s face was a deep purple bruise all over. (R2) spent a couple days in the ICU." V4 stated that R2 had a laceration on chin that had butterfly bandages on it and a bruise that ran from across chin to around mouth to top of mouth and ran to above top of mouth across upper lip. V4 stated R2 had bruises on R2's neck and shoulders. V4 stated that R2's left wrist was swollen badly but x-rays were negative for the wrist. V4 stated he received conflicting	S9999		

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S9999	Continued From page 8 information from V2 and V5 if R2's fall had been witnessed. On 2/11/2021 at 4:13 PM, V5 stated that she was the nurse for R2 on January 23, 2021 when R2 fell. V5 stated that one of the residents witnessed R2 fall. V5 stated that she did not see R2 fall. V5 stated that R2 had gone in another resident's room and when turned around to leave room R2's walker got caught in the door and R2 flipped her walker. V5 stated R4 had yelled for staff to help R2. V5 stated that R2 was not located in a high traffic area when she fell. V5 stated R2 was not receiving one-to-one supervision when she fell but staff were aware of R2's whereabouts. V5 stated at the time of the fall, staff was busy with meal trays and feeding other patients and would have been impossible to do 1:1 with R2, staff was too busy going in and out of other patient's rooms. V5 stated that R2 had been wandering, anxious and agitated that night and had to be re-directed several times. V5 stated redirection was not working so they tried to lay R2 down to rest. V5 stated R2's roommate yelled to us R2 was trying to get up, so we got R2 back up. V5 stated that management was aware of R2's increased agitation, increased behaviors and being hard to redirect. V5 stated they had all talked and thought it was due to R2 being in a different hall due to being on quarantine. V5 stated they thought R2 was agitated more due to wanting off of the hall to wander again to R2's old area. V5 stated that V2, DON, was checking with corporate the next day to see if R2 could be moved early from quarantine, but R2 fell before V2 got the answer. On 2/16/21 at 10:27 AM, V6, Certified Nurse's Aide/CNA, stated V6 had worked the night R2 flipped over her (enclosed ambulating	S9999		

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S9999	Continued From page 9 device/walker) on 1/23/2021. V6 stated they had put R2 to bed because they thought R2 was hurting and got R2 back up for dinner. V6 stated they thought R2 was more anxious/agitated because R2 was restricted to the hall because R2 was on quarantine. V6 stated she did not witness R2's fall, but it looked like R2 had tried to turn around in R4's room and got stuck in doorway. V6 stated that it depended on R2's level of agitation, if it was too bad, they would try to sit with R2 and calm R2 down, if R2 was just agitated because R2 couldn't go somewhere, they would just redirect. V6 stated, "(R2) was just on the main hall. I wouldn't say that is a high traffic area, because everyone is staying in their rooms with COVID and we are in with other residents a lot." V6 stated the only rules when R2 is in the (enclosed ambulation device/walker) is to keep an eye on R2, not one on one though. On 2/16/21 at 10:59 AM, V7, CNA, that R2 had been agitated and anxious the evening of the fall. V7 stated they tried to put R2 in bed before dinner, but R2 wasn't going for it. V7 stated they tried several things to redirect R2. V7 stated, "I tried toileting, but nothing worked, (R2) wants what (R2) wants, and that's the way it is." V7 stated "(R2) was roaming all over, that is why (R2) has the (enclosed ambulation device/walker). We had done everything. We thought (R2) was going to wear down and calm down. The business of dinner was making (R2) more agitated. I thought once that calmed down, I figured I could toilet (R2) again and (R2) would calm down." When asked if R2 was supposed to be in high traffic area when up in the specialized walker, V7 stated, "I don't know what that meant for sure, I don't know what it means in nursing home, staff are in the halls sometimes, so I guess that is high traffic." V7 stated, "One of the	S9999		

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cognitive residents was able to tell me what happened. They said (R2) was in the door frame of their room, where it is hinged, (R2's) (enclosed ambulation device/walker) got caught in that area. (R2) is like bull in china shop and will just keep shoving the walker and flipped it. I didn't hear (R2) as if in trouble, I just heard the walker flip."

On 2/16/2021 at 3:15 PM, R4 stated, "(R2) came in the room and wandered around their room. (R2) then turned around to leave and (R2) got the walker all cockeyed trying to get out the door. (R2) got the walker hung up on the door and just kept rocking it really hard, trying to get it to go. Before I could get up to help (R2), (R2) rocked it right over." R4 stated: "(R2) would come in our room a lot, (R2) would try to stay in here, but we would just tell (R2) it was a guy's room and (R2) couldn't stay in here and (R2) would eventually leave."

On 2/16/2021 at 2:45 PM, V2 stated, "The (enclosed ambulation device/walker) is a rectangular walker that goes around resident that we ordered for (R2)." V2 stated "There is no special rules or expectations for the staff when (R2) is up. Staff know when they see (R2) is lost, or in an area (R2) didn't fit, staff is to redirect (R2)." V2 stated "Yes, we keep (R2) in high traffic area when up in (enclosed ambulation device/walker), always in hallways, and there is staff always in hallways." V2 stated "Well the plan for that time is for the nurse to be in the hall doing med pass at that time when staff is in rooms feeding. The nurse must have been in a room with a resident at the time (R2) fell and in that short time period, (R2) fell." V2 stated they didn't have to keep their eyes on R2 at all times, because the (enclosed ambulation device/walker) allowed R2 to be able to get up and walk all over

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S9999	Continued From page 11 safely. On 2/16/2021 at 3:14 PM, V2 was asked how staff intervene to ensure R2 is not going into other resident's rooms. V2 stated "It is like I said before on high traffic area, the hall usually has staff in it, even if staff are feeding. We have the nurse in the hall working on passing medications. This time was just a fluke that nobody was in the hall at that time." The Facility's Fall Prevention (S.A.F.E.) policy and procedure documents, "DEFINITION: The S.A.F.E. program promotes Safety, Awareness, Fall, prevention and Education of both staff and residents." It continues, "3. Residents found to be at high risk for falls are placed on the S.A.F.E. program, and specific Interventions are implemented to meet individual need." Facility policy titled "Care Planning - Interdisciplinary Team," dated 1/2017, documents "Purpose: 1) To assess each residents strengths, weaknesses, and care needs. 2) To use this assessment data to develop a comprehensive Plan of Care (POC) for each resident that will assist a resident in achieving and maintaining the highest practical level of mental functioning, physical functioning, and well-being as possible." " B "	S9999		