Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012512	A. BUILDING: _____ B. WING _____	C 11/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON COUNTRYSIDE MANOR	606 EAST IL HWY 15 MOUNT VERNON, IL 62864

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S 000	Initial Comments Facility Reported Incident IL139836 of 10/13/21.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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. 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. These requirements are not met as evidenced by: Based on interview and record review the facility failed to provide required supervision, support and assistance, during an episode of agitation, that resulted in a fall for 1 (R3) of 3 residents reviewed for falls in a sample of 3. This failure resulted in R3 attempting to transfer independently and resulted in a fall. R3 sustained a fracture to the right femur, requiring hospitalization, a subsequent surgical repair, and then R3's demise on 10/15/21. This past noncompliance occurred from 10/13/21 to 10/25/21. This has the potential to affect 45 residents, assessed as high risk for falls, residing in the facility. Findins include: R3's Resident Profile Sheet documents admission to this facility on 12/29/20 with a	S9999		

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S9999	Continued From page 2 discharge date of 10/13/21. R3's Medical Diagnoses Sheet documents the following in part upon admission - History of falls, muscle wasting and atrophy, fatigue, viral pneumonia, acute respiratory failure with hypoxia, heart disease, atrial fibrillation and hypertension. R3's most recent quarterly MDS (Minimum Data Set) dated 09/08/21 documents the following: R3 is moderately cognitively impaired; and assessed as requiring extensive one person physical assist for bed mobility and transfers. R3's MDS also indicates that a one person physical assist is required to balance during transitions - moving from seated to standing position, as resident is not steady and only able to stabilize with human assistance. R3's Fall Risk Evaluation dated 09/08/21 documents a score of 14, with a score of 10 or greater indicating a high fall risk. R3's Care Plan dated 01/20/21with a revision date of 04/21/21, documents the following focus area in part - ..."I require assistance with my ADLs (activities of daily living)... I am A/O (alert and oriented) x3 with moments of forgetfulness/confusion. I am able to redirect easily and able to make my needs/wants known appropriately. I am legally blind. I require verbal cues and extensive staff assist with my ADL's and mobility ..." Interventions in part - ...I can walk with a wheeled walker, gait belt, and assist ..." R3's Care Plan also includes the following focus area dated 01/20/21 - "I am at risk for falls related to SOB (shortness of breath), weakness, fatigue, legally blind ...Interventions in part - ... I can be up to my wheelchair or walked with assistance and	S9999		

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S9999	Continued From page 3 wheeled walker; Check my positioning in bed to ensure that I am positioned away from the edge; Please use a gait belt when assisting me with transfers and ambulation ..." R3's progress note dated 10/13/21 at 6:05 AM by V4 (LPN) documents the following - " ...This nurse in restroom at this time and upon exiting restroom was called to resident room by CNA staff (V5, V7) went into room to investigate hearing resident yell out. (V5) stated to this nurse, I helped her get dressed for breakfast and she would not let the other CNA help. She was dressed with non-skid shoes on and was dressed after given incontinence care. I left her sitting on side of bed because she did not want to let me help her into w/c. She told me to get out of room. This nurse along with (V9 - LPN) did not move resident from laying position on right side of body with head at foot of bed and feet at top of bed. C/o (complaint of) extreme pain and did not roll over. Unable to perform complete assessment. Doctor along with V16 (Family Member/POA - Power of Attorney) called to notify. Vital signs are 99.7, 88, 18, 106/91 95% SPO2 (percent oxygen saturation) at room air." R3's Final Facility Serious Injury Incident Report dated 10/13/21 at 6:30 AM by V17 (Assistant Director of Nursing - ADON) document the following in part - "Detailed Incident Summary: Elder found on the floor on her right side at 6:30 AM this morning. Elder has had complaints of pain. Nurse assessed and obtained an order to send to (local hospital) emergency room for evaluation. X-ray at hospital showed mildly angulated intertrochanteric fracture proximal right femur resulting from fall." Update to report dated 10/16/21 at 12:08 PM by V1 (Administrator): Resident had surgery at hospital. Hospital	S9999		

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S9999	Continued From page 4 notified facility of resident passing on 10/15/21. Final Report dated 10/20/21 at 12:08 PM by V17 documents the following in part - "Elder was noted to be agitated the morning of 10/13/21. CNA assisted elder to clean up and get dressed for the day. According to the CNA, elder was upset at another CNA for not changing her in time. After elder was assisted in getting dressed she continued to be upset and ask that the CNA leave her alone. CNA left elder on the side of the bed to calm down as she requested. Shortly after CNA heard noise and went to elder's room noting her to be on the floor and then informed the nurse. Nurse immediately assessed and noted elder was in significant pain. Elder was sent to (local hospital) emergency room for evaluation where x-ray was obtained noting the fracture to the right femur. Elder would typically get up around this same time every morning, elder also known to get agitated with staff at times and refuse care ..." On 11/03/21 at 10:22 AM, V7 (CNA) stated that on the morning of 10/13/21, R3 appeared agitated with CNAs and other staff that were coming into R3's room. V7 stated that he (V7) proceeded to assist R3's roommate, R4 in getting up. V7 did ask if R3 would like him to assist her in getting up. R3 stated no. V7 stated R3 was soiled but refused my care. V7 stated he asked V5 (CNA) to go in to R3's room and assist her. V7 stated he had gone to the next room to give resident care and heard R3 yelling at V5 to get out. V7 stated, V5 relayed to him she has been able to provide care and get R3 dressed other than her pants being pulled completely up before R3 "kicked" V5 out of the room. V7 stated he was still in the room next door when he heard R3 yell. V7 stated he went to R3's door and observed R3 on the floor. V7 stated he got help, but staff were	S9999		

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already on their way to assist because they could hear R3 yelling. V7 stated he was not sure what R3's ADL assist requirements were because he worked at night and R3 was usually in bed. V7 stated he does not believe that any resident should be left alone on the side of the bed because they are all a fall risk.

On 11/03/21 at 10:32 AM, V5 (CNA) stated on the morning of 10/13/21, she came to work around 5:30 or 6:00 AM. V5 provided the following recount of R3's incident - "I came down the hall and her light was on. She asked me to help get her up. V7 came out stating she was distraught and asked if I could help her. She stated the boy that worked before me did not do anything for me." V5 continued to state, "I helped her get up, washed her off and got her dressed. She told me she was going to the bathroom. I asked her if she wanted me to help her pull her pants up, and she told me why pull them up, I'm going to the bathroom anyway." V5 stated "R3's pants had not been pulled above the hips and were just below her buttocks." V5 stated "she remembered R3 had on non-skid socks, no shoes yet." V5 confirmed usually every morning, once R3 gets on the side of the bed and gets help transferring to her wheelchair chair, R3 would roll to the bathroom, brush her teeth and comb her hair. V5 confirmed she left R3's room because she was hollering and screaming and told V5 to go. V5 also confirmed when she left R3's room, R3 was seated on the side of her bed. V5 stated she heard that R3 fell, so V5 and two other LPNs gave assistance. V5 stated R3 did not want to go to the hospital, but when the nurse asked R3 if she wanted to get up and R3 could not, the nurse called the ambulance. V5 confirmed, in hindsight, she would have stayed in the room with R3 but R3 was so agitated, she told me to get out. V5

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S9999	Continued From page 6 stated "she had not seen R3 that upset before." On 11/03/21 at 10:00 AM, V11 and V12 (Certified Nursing Assistant - CNA) stated they work the 200-hall and were very familiar with R3, as R3 did reside on this 200-hall while a resident in the facility. V11 stated she has worked here 19 years. V12 stated she has worked here for 20 years. V11 and V12 stated all residents have a care card on their door that reminds staff how a resident is assessed to require assistance and by what method. V11 and V12 stated this helps new staff or reminds long-time staff the resident's status and if it has changed. V11 and V12 stated R3 required transfer using staff assistance and a gait belt. V11 and V12 confirmed R3 would not be safe to sit on the side of the bed for the fact she would try to get up on her own. Both V11 and V12 stated they would have laid R3 back down in bed, prior to leaving the room, or asked another staff member to be in the room. On 11/03/21 at 2:00 PM, V10 (Restorative CNA) stated R3's MDS dated 09/08/21 documents that R3 needed (2) supportive, meaning touch support (which is what she (R3) was the majority of the time) and R3 required weight bearing with standby assist to stand, turn and pivot to wheelchair. V10 stated personally, after working here 19 years, she (V10) would never leave a resident alone on the side of the bed. V10 stated that she (V10) would not have left R3, she (V10) would have laid her (R3) back down in bed or would get another staff to at least do a standby observation in case she (R3) attempted to transfer herself. V10 further stated, R3 often transferred herself without asking for assistance first. She (R3) would say, "I know I'm not supposed to do that, but I (R3) just wanted to sit there."	S9999		

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S9999	Continued From page 7 On 11/04/21 at 9:40 AM, V4 (LPN) stated she was the nurse who wrote the initial incident report and called the ambulance on 10/13/21 when R3 had her fall. V4 stated, " I came in that morning. We were finishing shift to shift duties. I went to the bathroom before I started passing meds. I was organizing my med cart when the midnight nurse (V6 - LPN) and the other CNAs (V5, V7) tell me R3 had fallen. I went to R3's room and V6 was already there stating R3 was complaining of a lot of pain. R3 also complained of pain to me, so I made the decision not to move her. I called the doctor and the ambulance." When asked what level of assistance R3 required for transfers, V4 stated R3 required one person for transfers. V4 stated due to R3's history of falling, being hard of hearing, and not having good sight (legally blind), R3 would not be safe to sit alone on the side of the bed and attempt to transfer to her wheelchair without assistance. When asked whether V4 recalled if R3 was wearing non-skid socks only as V5 reported, V4 stated to the best of her recollection as she put in her report, she observed R3 with socks and shoes on at the time of the incident. On 11/04/21 at 6:14 PM, V13 (Primary Care Physician - PCP) stated she had been R3's PCP for many years. V13 stated she was aware R3 had fallen in the facility, underwent surgery, and subsequently passed away in recovery. V13 stated she does agree that R3 most likely threw a clot. V13 stated R3 could be difficult and insist she could do things on her own, could be very convincing and sometimes even agitated, but R3 was not steady enough to transfer herself from the bed to her wheelchair. V13 confirmed R3 did not have good judgement regarding her physical capabilities, nor the decision-making ability to	S9999		

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S9999	Continued From page 8 determine whether she was safe to transfer from a bed to a wheelchair without assistance. R3's hospital history and physical (H & P)) dated 10/13/21 at 7:31 AM documents a chief complaint of - Right hip pain after a fall. History of Present Illness: Patient admitted after a fall in the nursing home this morning. Patient was trying to transfer from bed to the wheelchair to go to the bathroom. She asked for help, but couldn't get help, she lost her balance and fell on her right side, no loss of consciousness, no head injury. X-ray showed intertrochanter fracture of right hip, closed, orthopedic consulted in emergency room. Patient is on anticoagulant Pradaxa for atrial fibrillation. R3's hospital x-ray report dated 10/13/21 at 8:28 AM documents the following in part - mildly angulated intertrochanteric fracture proximal right femur. No significant displacement. No bone destruction. R3's H & P dated 10/13/21 Medical decision making and plan document - status post mechanical fall; intertrochanteric fracture of right hip, closed fracture; orthopedic consulted in emergency room - Will hold Pradaxa per ortho will need to wait 2-3 days to do surgery. R3's hospital Operative/Procedure Report dated 10/15/21 at 8:12 PM by V15 (Orthopedic Surgeon) documents the following in part - Procedure: Open reduction internal fixation (ORIF) hip/trochanteric (fixation nail); Date of Service: 10/15/21; Pre-Op Diagnosis: right intertrochanteric femur fracture; Post-Op Diagnosis: Same. V13's report describes the procedure in detail ending in his observation of R3 in recovery moving extremities with pedal pulses palpable upon assessment.	S9999		

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S9999	Continued From page 9 V13 documents an addendum to his operative report as follows - "After I saw her in recovery, less than an hour after getting to recovery, she went into cardiac arrest. She was coded, but the family asked the code to stop, stating that she would not want that, so she, R3, passed away." R3's Certificate of Death Worksheet dated 10/15/21 documents the cause of death as: a) Probable pulmonary embolism, due to or as a consequence of b) While recovering from hip surgery, due to or as a consequence of c) Fall at nursing home Date Pronounced: 10/15/21. Time of Death: 7:37 PM. A facility policy titled; "Falls Prevention Program" dated revised on 10/15/21 documents the following in part - "Fall Prevention Program Components: ... 1. Method to identify risk factors: a) Fall risk score; b) Resident transfer assessment; c) History of falls; ...f) Discussion of individual circumstances ...Physical Capabilities: ...4. How to determine resident is at risk for falls: e) MDS - Codes the resident as type of assistance required and the amount of assistance required. Addresses standing/sitting balance, mobility, gait, vision and cognitive status. (A)	S9999		