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
	IL6008007	A. BUILDING: _____ B. WING _____	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(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 2217589/IL151481	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) These Regulations are not met as evidenced by: Based on observation, interview, and record review the facility failed to supervise a resident at high risk for falls for 1 of 6 residents (R1) reviewed for falls in the sample of 6. The facility failed to ensure fall interventions were in place for 3 of 6 residents (R2,R3, R5) reviewed for falls in the sample of 6. This failure resulted in R1 being found on floor in an unsupervised area and sustaining a head laceration requiring 5 staples. The findings include: 1. On 9/22/22 at 10:13 AM, R1 was sitting in her wheelchair at the nurse's station. R1 had a 4 cm laceration to the right posterior side of her head with 5 staples visible. V4 Licensed Practical Nurse (LPN) stated "R1 is at high risk for falls, she is one of my star pupils, you have to watch her. R1 has Dementia and thinks she is at work and when she's done working, it's time to leave and she tries to get up. R1 will get antsy and try to stand up and with her Parkinson she is shaky. R1 has had falls the most recent was Tuesday	S9999	**Attachment A** Statement of Licensure Violations	

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night (9/20/22). She fell and was sent out and got 5 staples in the back of her head. R1 has a clip alarm and a sensor alarm, and we put her at the nurse's station for close monitoring."

On 9/22/22 at 11:40 AM, V3 Assistant Director of Nursing (ADON) stated R1 tries to get up and down from the chair, mostly on the PM shift. V2 Director of Nursing (DON) with V3 stated R1 had a fall on 7/23/22, 8/12/22, and 9/20/22. V3 stated after R1's 7/23/22 fall, R1 already had bed/chair alarms in place, bolsters to the bed were added, toileting before bed was added, and 4 months of R1's blood pressure readings were sent to the doctor for review. V3 stated after the 8/12/22 fall, they added a tab alarm and close monitoring (keeping R1 at the nurse's station).

R1's Fall Huddle shows R1 had an unwitnessed fall on 7/23/22 where R1 was found sitting on the floor in her room, a witnessed fall on 8/12/22 where R1 stood up from her wheelchair and fell, hitting her head and sustaining a Hematoma on her right forehead, and an unwitnessed fall on 9/20/22 where R1 was found on the floor at the nurse's station with a laceration to her head.

R1's Fall Risk Evaluation date 8/12/22 shows "R1 is at risk for falls and has intermittent confusion, 1-2 falls in the past 3 months, and has decreased muscular coordination and a balance problem while walking."

R1's Care Plans shows R1 has diagnoses of history of falling, Unspecified Dementia, Psychotic disturbance, Mood disturbance, Anxiety, and Meniere's disease. The same Care Plan shows R1 is at risk for falls related to cognitive loss, impaired balance, incontinence, impaired visual status, unaware of her risk factor

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S9999	Continued From page 2 or safety needs, hospice care for declining condition, history of falls, and requires repeated verbal directions and hands on assist to complete bed mobility, transfers, ambulation, re-directions and locomotion. On 9/22/22 at 12:32 PM, V7 Certified Nursing Assistant (CNA) stated on 9/20/22 R1 was at the nurse's station table, herself and the nurse (V6 LPN) were sitting there charting. V7 stated R1 sometimes tries to stand up and was at the nurse's station to be watched. V7 stated she answered a call light down the hall. V7 stated a residents colostomy bag had broken for the second time that night and she called V6 to come to the resident's room to change it (leaving R1 alone at the nurse's station). V7 stated there was a big mess, with the colostomy and V6 was occupied for a long time in that resident's room. V7 stated V6 finished up and left the room and she continued to clean up the resident. V7 stated when she left the room and went to the nurse's station, R1 was on the floor and V6 was holding her head and stated he found R1 on the floor. V7 stated there was another CNA working with them (V9) but she did not see her before going to the residents room and was not sure where V9 was during that time. V7 stated neither herself nor V6 heard any alarms while in the resident's room with changing/cleaning the colostomy. On 9/22/22 at 1:23 PM, V9 CNA stated on 9/20/22, R1 was at the nurse's station with V7. V9 stated she informed V6 that she was going to take her break and then left the floor. V9 stated when she returned from break, R1 was bleeding, and she was told R1 had fallen. V9 stated R1 was at the nurse's station to be watched, R1 is a well-known fall risk and tries to get up.	S9999		

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S9999	Continued From page 3 On 9/22/22 at 11:56 AM, V5 Nurse House Supervisor stated he works the PM shift and sees R1 with behaviors of standing up and R1 talks about going home. V5 stated R1 is on close monitoring which is when they try to have someone near her at all times. V5 stated he was working on 9/20/22 and was notified when R1 fell that night. V5 stated when he went down to that unit, he saw R1 with a laceration on the top right side of her head and recommended R1 be sent to the hospital. On 9/22/22 at 1:30 PM, V2 stated close monitoring is keeping the resident in common areas, nurses' station, or a high visibility area where staff are within eyesight of the resident. V2 stated R1 was on close monitoring. On 9/22/22 at 1:59 PM, V3 stated if residents are at the nurse's station for close monitoring and the staff has to step away, they should get someone to watch those residents and not leave them unattended. V3 stated it is not an ideal situation to leave the resident alone at the nurse's station with no way to call for staff assistance. R1's Progress Notes dated 9/20/22 at 8:15 PM, shows "resident involved in an unwitnessed fall in the day room, hit back of her head, has a 4 cm gash that was bleeding. Resident is conscious, appears to be in pain. Sent out to the hospital." R1's After Visit Summary from the hospital dated 9/20/22 shows "Reason for visit: Fall, Diagnoses: Head injury, scalp laceration, and Done Today: laceration repair....staples." R1's Progress Note dated 9/21/22 at 12:05 AM, shows "returned from hospital, 5 staples to posterior head."	S9999		

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2. On 9/22/22 at 9:05 AM, R2 was observed sitting in a reclining wheelchair in her room by herself eating breakfast. R2 had an alarm hanging on the back of the wheelchair. The cord that connects the sensor pad to the alarm was not plugged into the alarm box.

R2's Minimum Data Set (MDS) dated 7/26/22 shows R2's cognition is moderately impaired.

R2's Care Plan dated 7/22/22 shows R2 is at risk for falls related to impaired balance, impaired visual status, poor safety awareness and is dependent on staff for transfers and locomotion. This same Care Plan shows R2 has an intervention of "Chair alarm when up in chair/wheelchair, staff will check placement and function."

3. On 9/22/22 at 9:12 AM, R3 was observed sitting in her wheelchair at the dining room table. R3 had an alarm on the back of her wheelchair. The cord that connects the sensor pad to the alarm was not plugged into the alarm box.

R3's MDS dated 9/13/22 shows R3 is cognitively impaired.

R3's Care Plan dated 9/8/22 shows R3 is at risk for falls related to unaware of safety needs at times, history of falls prior to admission, limited mobility, alteration in endurance, cognitive loss and requires verbal directions and hands on assist for transfers and locomotion.

4. On 9/22/22 at 10:14 AM, R5 was observed sitting in her wheelchair with a chair alarm hanging on the back of the chair. The chair alarm box was not flashing green. V4 LPN stated the

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S9999	Continued From page 5 chair alarms are working when the sensor pad is plugged into the box and the light is flashing green. V4 looked at R5's alarm and stated it was not working for some reason, the light is not on. R5's Care Plan shows R5 is at risk for falls related to forgetfulness, impaired balance, and requires assist from staff for mobility, transfers, and ambulation. This same Care Plan shows an intervention of a chair alarm and for staff to check placement and function each shift. The facility's Fall Reduction Program Policy shows "It is the policy of this facility to have a fall reduction program that promotes the safety of residents in the facility....assigned nursing personnel; are responsible for ensuring that the ongoing precautions are put in place and consistently maintained.....the use of alarms require on-going monitoring to determine functionality; alarms shall be checked for placement every shift and functioning to be tested." (B)	S9999		