STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003750	A. BUILDING: _____ B. WING _____	C 02/10/2022

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TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

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S 000	Initial Comments Complaint Investigation: 2221038/IL143305	S 000		
S9999	Final Observations 300.610a) 300.610c)4)A 300.610c)4)F 300.1210b) 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. c) The written policies shall include, at a minimum the following provisions: 4) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 A) Analysis of the risk of injury to residents and nurses and other health care workers taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs; F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident 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. 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 were not met as evidenced by:	S9999		

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S9999	Continued From page 2 Based on observation, interview, and record review, the facility failed to ensure a resident's care plan was reviewed and updated to include interventions to address their level of dependence for activities of daily living, including bed mobility. The Facility also failed to ensure two staff assisted with bed mobility as assessed in the Minimum Data Set (MDS) assessment and failed to identify the root cause of a fall for one of three residents (R1) reviewed for care plans in a sample of three. This failure resulted in R1's care plan not including Minimum Data Set (MDS) assessment data which documented R1 required extensive assistance of two people for cares which also resulted in R1 falling out of bed while being cared for by only one staff member causing R1 to sustain two forehead lacerations and a fractured cervical vertebrae which required hospitalization. Findings include: A Care Plans (Comprehensive) policy dated 4/2015 documents, "An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and/or psychological needs is developed for each resident." This policy also documents, "Care plans are revised as changes in the resident's condition dictates." An Accident and Incident Investigation Guidelines policy (undated) documents, "An accident/incident investigation is not designed to find fault or blame, it is an analysis to determine causative factors that can be controlled or eliminated to prevent future occurrences, potential injuries or abuse."	S9999		

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A Falls-Clinical Protocol policy dated 2005 documents, "For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall." This policy documents, "Causes refer to factors that are associated with or that directly result in a fall," and "The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling and fall risk."

R1's Minimum Data Set (MDS) assessment dated 1/19/22 documents R1 is moderately cognitively impaired, requires extensive assistance of two people for bed mobility, toilet use, personal hygiene, and is totally dependent on two people for transfers.

R1's current Care Plan documents that R1, "is limited in her ability to move independently in the bed r/t (related to) decreased mobility and generalized weakness and requires a restorative bed mobility program." This same Care Plan does not include interventions to address R1's requirement to have two people provide extensive assistance with bed mobility, toilet use, or personal hygiene.

R1's Facility Incident Report Form dated 1/29/22 documents that on 1/29/22 while R1 was lying on her left side during cares, R1's locked bed moved to the right causing R1 to roll out of bed and onto a staff member. This report documents that R1's head hit the oxygen machine during the fall causing two forehead lacerations and a nondisplaced fracture to the C6 cervical spine. R1's incident report form documents that the "occurrence resolution" was that R1's bed would

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be inspected and serviced by maintenance to fix any mechanical problems."

R1's Occurrence Report dated 1/29/22 states that "(R1) observed on floor with CNA (Certified Nurse Aide) attempting to hold resident up, blood noted on floor," and "Staff was rolling resident (R1) to left side using (incontinence) pads as support. Staff had (R1) on left side and bed moved out to right and resident started to roll left, on to staff. Staff attempted to move oxygen concentrator but unsuccessful. Resident hit concentration with her head." This report further documents R1 sustained two lacerations to her forehead and a nondisplaced cervical spine fracture.

R1's hospital Physician's progress notes dated 1/30/22 document that R1 sustained an acute head injury, a nondisplaced C6 (Cervical) vertebral body fracture and a right forehead scalp hematoma/laceration as a result of a fall at the facility.

R1's CT (Computerized Tomography) Cervical Spine report dated 1/29/22 documents, "Findings are suspicious for a nondisplaced fracture through the anterior superior endplate of C6."

On 2/9/22 at 3:05p.m. R1 was lying in bed with her eyes closed. R1 had two large lacerations situated vertically on the right side of R1's forehead. One laceration measured approximately 7cm (centimeters) long and the second one measured approximately 5cm long. R1 was wearing a neck brace around her neck. V4 (Maintenance) entered R1's room to demonstrate that after R1's fall, he applied a block under R1's wheel at the end of her bed to prevent R1's locked bed from moving. The block was flat on the bottom but curved on top where

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the wheel sat on top of the block. V4 stated that he does not understand how R1's bed could have moved with the wheels locked. V4 stated R1's bed is brand new and has features which prevent the bed from moving easily when the wheels are in the locked position. V4 stated after R1's fall, he inspected R1's bed and had to use extreme pressure to cause R1's locked bed to move. V4 stated he can't understand how R1's bed could have moved with the wheels locked and during normal resident care activities. V4 stated that despite his difficulty moving R1's locked bed, he applied a block underneath R1's bed wheel to prevent it from accidentally moving during cares in the future.

On 2/10/22 at 9:54a.m. V6 stated she was the CNA caring for R1 when R1 fell from the bed on 1/29/22. V6 stated she was the only person in R1's room providing care. V6 stated that some CNAs use two people to provide incontinence care for R1, which includes bed mobility. V6 stated that she believes R1 is calmer when only one person is in the room providing care. V6 stated that because of this, V6 does not use the assistance of another staff person when providing bed mobility, toileting, or personal hygiene to R1. V6 stated that on 1/29/22 while she was turning R1 in the bed while preparing to get her up for lunch, V6 turned R1 to her left side facing the window. V6 stated that she isn't sure if the bed moved, but something happened to cause R1 to tumble forwards out of bed and onto V6's lap. V6 stated that R1 hit her head on the oxygen machine during the fall causing two large lacerations to R1's forehead. V6 stated that she was not given any instructions to use two staff members while providing activities of daily living (ADL) care for R1, including bed mobility. V6 stated the only time two staff members are

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required to assist R1 is when R1 is being transferred using the mechanical lift.

On 2/10/22 at 9:15a.m. V2 (Director of Nurses) stated she was R1's nurse the day R1 fell out of bed on 1/29/22. V2 stated V6 (Certified Nurse Aide/CNA) was providing cares for R1 without the assistance of another CNA. V2 stated that V6 was providing R1 with incontinence care and dressing her before getting R1 up in a chair for lunch. V2 stated that normally there are at least two if not three staff assisting with R1's cares. V2 stated she prefers that at least two staff are in R1's room during cares because of R1's size and because of R1's ADL (Activities of Daily Living) abilities. V2 stated that R1 is a larger resident requiring a bariatric mechanical lift and she also gets anxious during cares which makes R1 "shaky." V2 stated that at times there will be two staff on one side of R1 and two staff on the other side to turn and reposition R1 for bed mobility. V2 stated, "When I have helped with (R1) it has been difficult for (R1) to stay on her side. One time we had two (staff) on one side (of R1) and one on the other side. I felt safer that way so we could give her (R1) extra help." V2 stated, "With incontinence care (for R1), I would have two (Staff). I would prefer two." V2 stated that on 1/29/22, V6 "started hollering for help." V2 stated that when she entered R1's room, "(R1) was lying on the floor. (V6) had worked herself out from under (R1) and was still down with (R1) trying to support (R1)." V2 stated another nurse and a CNA came into the room to help. V2 stated they tried to move the bed out of the way so the stretcher could be brought into the room by paramedics. V2 stated R1's bed did not move freely. V2 stated that R1's bed also had an air mattress in place which was inflated to help prevent R1 from developing pressure ulcers. V2

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S9999	Continued From page 7 stated that in her opinion, while V6 was trying to hold R1 up on her side, without assistance from another person, R1's air mattress inflated behind R1 pushing R1 out of the bed. V2 stated, "It should have been two people," providing R1's cares because of R1's size, ADL abilities, and because of the air mattress. On 2/10/22 at 11:30a.m. V1 (Administrator) stated that she recently became the Administrator for the facility after serving as the Director of Nurses for eight years. V1 verified that R1's MDS dated 1/19/22 documents that R1 requires extensive assistance of two staff for activities of daily living including bed mobility. V1 verified that R1's care plan does not indicate that R1 requires the extensive assistance of two staff for ADLs, including bed mobility. V1 stated R1's care plan should have included this information for how to provide R1's care. V1 stated that CNA staff do not have access to residents MDS assessments. V1 stated that CNA staff, including V6, do have access to each residents' care plan so they can review what interventions are required to care for them. V1 also verified that V6 was the only person in R1's room providing cares on 1/29/22 when R1 fell out of bed. V1 stated the facility concluded R1's fall was because R1's bed may have moved while the wheels were locked and while V6 was turning R1 in her bed. V1 verified that R1's MDS assessment, which was completed prior to R1's fall, documents R1 requires the extensive assistance of two people for activities of daily living including bed mobility. (A)	S9999		