STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000723	A. BUILDING: _____ B. WING _____	C 04/19/2022

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HERITAGE HEALTH-CARLINVILLE	1200 UNIVERSITY AVENUE CARLINVILLE, IL 62626

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S 000	Initial Comments Complaint Investigation: #2242853/IL145691	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b)5) 300.1210 c) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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. 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 supervision and effective fall interventions for 1 of 4 residents (R2) reviewed for supervision/falls in the sample of 4. This failure resulted in R2 falling twice in less than a 24-hour period. R2 was hospitalized with a displaced a nasal bone fracture on both sides with a soft tissue injury resulting in bruising and swelling to forehead, face and left eye, a fracture to the upper spine and multiple right sided rib fractures.	S9999		

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S9999	Continued From page 2 Finding includes: R2's Admission Record, print date of 4/14/22, documented an admission date of 12/1/21 and medical diagnoses of unspecified dementia with behavior disturbance, psychotic disorder with delusion, anxiety, major depressive disorder, osteoarthritis and osteoporosis. R2's Minimum Data Set, dated 2/11/22, documented R2 had moderately impaired mental cognition. R2's Fall Risk Assessment, dated 1/18/22, documented R2 was at high risk for falls due to R2 has a normal gait and a mental status to, overestimates or forgets limits and history of falling. R2's Care Plan, with initiated date of 12/1/21, documented, "Fall/Safety: I am at risk for falls. I have diagnoses of dementia, hypertension, anxiety, depression, vertigo, fibromyalgia, delusions, arthritis, hypocholesteremia, cervicalgia. I have poor safety awareness due to impaired cognition. I ambulate in my room without assistance and frequently forget to use my walker. I do not understand the use of the call light and I do not ask for assist. I require staff assist with ADL's (activity of daily living). I am incontinent at times. I am ambulatory with use of walker, and I do not always use it. I at times require use of wheelchair. I have adequate vision with use of eyeglasses. I have adequate hearing. I receive medication that may increase my risk for falls (antidepressant, antipsychotic, antianxiety, narcotic pain medication." R2's Care Plan Interventions, dated 12/1/21 are as follows: Make sure call light is in reach, reminders to use walker, and assist to keep non-skid footwear on	S9999		

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S9999	Continued From page 3 at all times. R2's Fall Care Plan, revision date of 2/24/22, documents "May have a mattress on the floor." The same Care Plan documented, "Behavior/Mood(R2) has dementia, anxiety a delusion disorder, displays behavior of rummaging through her belongings, frequent crying, refusing care, yelling out and insomnia." These interventions are documented with initiation date of 12/8/21. R2's, Progress Notes, for the following dates in March 2022, documented: On 3/21/22 R2 was standing at bedside with confusion talking to staff. On 3/22/22 R2 was slightly agitated, "does not know what to do." On 3/25/22 R2 observed in her room screaming and had pulled all of her clothes out of the closet. Clothes were on floor, bed and bedside table. R2 yelling, "she does not know what to do." On 3/29/22, R2 was yelling due to the placement of personal items, R2 crying and "I don't know what to do." and R2 stripping bed linens. On 3/29/22, R2 was observed to have clothing from her closet stacked on wheeled walker and was placed in hallway, R2 stating she denies these are her clothes and threw on the floor. On 3/30/22 R2's Physician and Nurse Practitioner were notified of R2's increased behaviors, order received to increase R2's Seroquel to 50 mg (milligrams) po (by mouth) BID (two times a day) with a start date of 4/3/22 for Dementia with Behavioral disturbance. R2's Progress Note, dated 4/4/22 at 3:24 PM, documented a physician's orders received to transfer R2 to the local Emergency Department, regarding R2's statements of yelling and wanting	S9999		

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S9999	Continued From page 4 to kill herself. The note documented R2 was transferred out at 3:55 PM. R2's Progress Note, dated 4/4/22 at 9:09 PM, documented R2 returned to facility with Ativan 0.5mg (milligrams) IM (intramuscular) received at hospital. R2's 15 Minute Visual Check Sheet, dated 4/4/22, documented R2 had received 15-minute checks starting at 9:20 PM, every 15-minutes that ended on 4/5/22 at 2:20 AM. The 15-minute entries documented the following on 4/5/22 from 1:35 AM until 2:50 AM: 4/5/22 1:35 AM sitting up on bed 4/5/22 1:50 AM sitting up on bed 4/5/22 2:05 AM in bathroom-screaming 4/5/22 2:20 AM in bed, screaming, yelling, crying There were no entries after this documenting how the staff addressed R2's behaviors to ensure she was safe. R2's Post Fall Investigation, dated 4/5/22 at 2:30 AM, documented, R2 found on floor, in room, barefoot, confused, and trying to get out of bed. This Post Fall Investigation did not document a fall mat/mattress was in place at the time of R2's fall. R2's Hospital Discharge instructions, date of service on 4/5/22 at 3:41 AM, documented R2 was treated for a head injury with contusion of the right side of the chest and right hip. R2's, Progress Note, dated 4/5/22, at 7:08 AM, documented R2 returned from the hospital, placed in bed with call light and personal items in reach and 15-minute safety checks continues. The Note documented R2 was educated on using call light and waiting for assistance for all	S9999		

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S9999	Continued From page 5 transfers. R2's 15-minute visual check sheet for 4/5/22, which documented at 7:05 AM, "returned per ambulance assisted to bed." There are no other 15-minute visual times documented after this entry. R2's Progress Note, dated 4/5/22 at 7:26 AM, R2 found on the floor in her room, yelling for help. The Note documented R2 was found lying on her left hip with copious amount of blood that appears to be coming from her nose and a hematoma forming in the middle of her forehead and complaining of neck and left shoulder pain. R2's Progress Note documented R2 was transported out on 4/5/22 at 7:47 AM, to the Emergency Room for evaluation and treatment. This Progress Note did not document there was a fall mat/mattress in place at the time of this fall. R2's, Hospital Emergency Department Radiology Report, dated 4/5/22, documented R2 with the following injuries: Acute variable-displaced left 9th-11th right rib fractures, bilateral acute slightly rightward-displaced nasal bone fractures with soft tissue swelling about the bridge of the nose, acute fracture of the T1 (thoracic) vertebral (base of neck area). R2's "Trauma History and Physical, Acute Care Surgery Service", dated 4/5/22 at 1:33 PM, documented R2 was transferred from outlying facility for evaluation and treatment due to a fall at nursing facility with hospital diagnoses: Bilateral Nasal bone fracture, fall, thoracic fracture, multiple right sided rib fractures, Dementia. R2 was then admitted. R2 returned to facility on 4/11/22 at 5:40PM.	S9999		

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S9999	Continued From page 6 There was no documentation in R2's medical record that the staff implemented any other interventions to prevent R2 from future falls after she returned from the hospital. R2's Care Plan was not revised after R2 returned to the facility on 4/11/22 with progressive interventions to address R2's high risk for falls and need for supervision. R2's Progress Note, dated 4/12/2022 at 10:03AM, documented, "At approx (approximately) 0800, (R2) called out that she was on the floor. Activity Director entered the room to observe (R2) sitting on the floor beside her bed." There was no documentation in this Progress Note that R2 was receiving one-to-one supervision when this fall occurred. On 4/18/22 at 9:00 AM, V1, Administrator stated R2's one on one supervision began when R2 returned to facility on 4/11/22, when R2's son could not provide the one on one for his mother. V1stated the facility has tried with Psychological evaluation which were unsuccessful, offered activities, provided a roommate change, none of these interventions had worked regarding R2's falls. V1 stated "I don't know what to do to keep (R2) safe." On 4/14/22 at 3:05 PM, V5, Certified Nurse Aide, (CNA) stated before R2 had a room change, R2 had resided down the 400-hall. V5 stated R2's bed was near the window. V5 stated R2 would only play with her call light, she could not use it. V5 stated R2 had signs posted to 'Call Don't Fall', but she didn't follow or understand the meaning and she did not have fall floor mats. V5 stated that 15-minute visual checks are when you check on the resident, but not sit in the resident's room. On 4/14/22 at 3:10 PM, V6, Licensed Practical	S9999		

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S9999	Continued From page 7 Nurse (LPN), stated she cared for R2. V6 stated R2 was constantly getting up without assistance, walking in her room, re-direction was provided but was not affective. On 4/18/22 at 8:20 AM, V4 CNA, stated she had cared for R2 before her fall and R2 did not know how to use the call light, one time pulled it out of the wall. V4 stated R2 never slept, up walking in her room, agitated, pulling clothes out of her closet and drawers and would throw them on the floor. V4 stated she knows if 15-minute checks need to be done for a resident, you make visual contact and return in 15 minutes. On 4/18/22 at 9:00AM, V3, Registered Nurse, stated, I know R2's new Fall interventions for 4/4/22 and 4/5/22 are documented in the Care Plan. V3 continued to state. "So how do you place new fall interventions, when she (R2) fell two times back-to-back and didn't return until 4/11/22?" The Facility's Policy and Procedure, entitle, "Fall Assessment and Management," dated 4/2019, documented, "It is the policy of this facility to assess each resident's fall risk on admission, quarterly, and with each fall. This will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk. Factors related to the risk will be addressed and care planned." (A)	S9999		