STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005367	A. BUILDING: _____ B. WING _____	C 02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-MINONK	201 LOCUST STREET MINONK, IL 61760

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S 000	Initial Comments Facility Reported Incident of February 6, 2022 IL143513	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 a) 300.1210 b) 300.1210 d)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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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 are not met as evidenced by:

Based on interview and record review, the facility failed to follow established fall interventions for repeated falls for one of three residents (R1) reviewed for falls in a sample of three. This failure resulted in R1 experiencing a fall and subsequently being diagnosed with a femoral neck fracture and dislocation.

Findings include:

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S9999	Continued From page 2 Facility Fall Assessment and Management Policy, revised 4/2019, documents: It is the policy of the 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 and factors related to the risk will be addressed and care planned; the interdisciplinary care plan will be person centered to reflect the specific needs and risk factors of the resident; the fall risk assessment may address general state of health, mobility, mental status and previous falls; interventions will be based on the fall risk assessment and circumstances surrounding the risk for injury or actual injury or fall (examples, falls related to gait/balance, confusion, toileting needs, environmental hazards or poor judgement or knowledge deficit); and a licensed nurse will consult with the resident care givers and other interdisciplinary team members in regards to future intervention, and resident specific risk factors. Facility Certified Nurse Aide/CNA Job Description, effective 9/1/2018, documents: Job functions including: routinely turn and position residents, assist with development and review of resident care plans in conjunction with nursing and other disciplines; detect, correct and report to the charge nurse any unsafe conditions which may result in bodily injury; provide maximum resident care services to assure well being of resident to greatest degree; assist with the execution of resident assessment and plan of care; assure physical comfort and safety; and assist in daily requirements and tasks in care and treatment of residents such as toileting, dressing and moving residents from area to area.	S9999		

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S9999	Continued From page 3 Facility Fall Occurrence Report, dated 2/15/22, documents R1's falls on 11/21/21, 12/18/21, 12/24/21 and 2/16/22. R1's Facility Final State agency report, dated 2/7/22, documents R1 sustained a fall with a Left Femoral Neck Fracture on 2/6/22. R1's Death Certificate, dated 2/13/22, was reviewed and documents significant injuries contributing to death, but resulting in underlying cause (Stroke) includes Femoral Neck Fracture. R1's current Care Plan documents: R1 has mild cognitive status and is alert with forgetfulness; R1 is at risk for falls due to limited mobility/strength/balance with walking altered cognition/not able to understand limitations and poor safety judgement; As of 9/15/21, assist R1 to keep non-skid footwear on at all times while up; As of 11/2/21 R1's needs staff assistance for mobility (walker and gait belt) and pulling clothes up and down during toileting; As of 12/24/21 verify that R1 has non-skid socks on when assisting with care/transfers/ambulation with staff rounding. R1's Risk Watch General Information, dated 11/21/21 at 3:00 pm, documents R1 slid off a new mattress on the bed, in R1's room. R1 did not sustain injury, and the intervention was a mattress support added to the bed. R1's Risk Watch General Information, dated 12/18/21 at 6:15 pm, documents R1 was found sitting on the floor in the front of the commode, urine on floor, walker tipped on side, and commode in upright position. R1 did not sustain any injury, and the intervention was to monitor for signs of urinary frequency, symptoms of Urinary	S9999		

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S9999	Continued From page 4 Tract Infection/UTI, push fluids monitor intake/output and to monitor that R1 had "Non skid socks on as she gets up frequently without shoes." R1's Risk Watch General Information, dated 12/24/21 at 12:46 am, documents R1 was found sitting on the floor, next to the commode. R1 did not sustain any injury, and it was determined R1 was non-compliant to call and ask for help and had on regular socks and no shoes. The intervention was to "Encourage and verify resident has non skid socks on during cares, transfers/ambulation and staff rounding throughout the night." R1's Risk Watch General Information, dated 2/6/22 at 1:00 pm, documents R1 was found lying on R1's back on the floor by the doorway, and pants were noted around R1's ankles. R1's walker was not in use, and R1 had regular socks on. R1 complained of pain in left upper leg and was unable to bear weight on left foot. Staff reminded R1 (forgetful and oriented by one/confused) to not get up on own, and to use the call light to notify for staff assistance. R1's Nursing Progress Note, dated 2/6/22 at 1:54 pm, documents R1 was observed lying on R1's back on the floor by the doorway, had on regular socks, complained of left upper leg pain, and was unable to bear weight on left foot. R1's Certified Nursing Assist/CNA and Nurse Post Fall Investigation, dated 2/7/22, documents R1 had a fall, on 2/6/22 at 1:00 pm, in R1's room. The Fall Investigation documents R1 was going to the bathroom, without a walker, and was found on the floor by R1's doorway. The Fall Investigation also documents R1 (oriented by	S9999		

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S9999	Continued From page 5	S9999		

one/confused) was alone/unattended and had on regular socks. The staff put on non skid socks after the fall, and reminded R1 to not get up by self and to use the call light. The root cause of the fall was R1 got up, took off the non-skid socks, and put R1's regular socks on prior to the fall. The intervention was to remove all regular socks from R1's room.

R1's Nursing Progress Note, dated 2/6/22 at 8:30 pm, documents notification to R1's hospice nurse for complaints of upper left leg pain and emesis.

R1's Patient X-Ray Report, dated 2/7/22, documents: "Left femoral neck fracture with subtle lateral upward dislocation of femur shaft."

On 2/15/22, at 11:58 am, V3 (Care Plan Nurse/Licensed Practical Nurse) stated, "I was actually the nurse on call on the day that (R1) fell. Last fall, (R1) had a fall when she lived on our Annex hallway, so we moved (R1) over to skilled unit after (R1) returned from the hospital, and she has been over here on the skilled unit ever since. (R1) needs constant reminders because of cognitive loss, which is actually one reason why we moved her over here to skilled to begin with. We had implemented interventions for non-skid socks on (R1's) previous falls. Then (R1) tested positive for COVID on 2/3/22 and we had to move her to the COVID unit, and we realized that we forgot to remove her regular socks from her drawers, because (R1) always forgot and would continuously put them back on. On 2/6/22, (R1) somehow put on regular socks and that is what was on her when she had that last fall. I am not sure why the staff did not catch her in the regular socks prior to the fall, but they should have, so we made sure that we removed all of her regular socks out of the COVID room, because she had a

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S9999	Continued From page 6 history of always changing her socks. All of the previous fall interventions were on (R1's) Care Plan. We got an order for an X-Ray the following day (2/7/22) because (R1) was complaining of left leg pain and that is when we found out she had a fracture." (R1's) family did not want (R1) sent out for surgical intervention because (R1) was on Hospice and ended up passing away on Sunday (2/13/22)." On 2/16/22 at 12:31 pm, V5 (Licensed Practical Nurse/LPN) stated, "I was the nurse the day (2/6/22) that (R1) fell. The last time I saw (R1) was during my morning medication pass, which would have been around 8:00 am, and (R1) had regular socks on at that time. Then around 1:00 pm, when I got called to (R1's) room for the fall (R1) still did not have non skid socks on, but had regular socks on still and (R1's) pajama pants were around (R1's) ankles." On 2/15/22, at 12:15 pm, V1 (Administrator) stated, "(R1) had a fall right after we moved her to the COVID wing, on 2/6/22. (R1) did not have on (R1's) non skid socks at the time of the fall and ended up with a left femur fracture. (R1) actually passed away in our facility on 2/13/22." (A)	S9999		