STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004352	A. BUILDING: _____ B. WING _____	03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY NURSING PAVILION	9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457

(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 Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b)5) 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 care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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 observation, interview and record review, the facility failed to monitor and keep residents free of accidental hazards for 1 of 3 residents(R36) at risk for falls and with history of falls in the sample of 15. This failure caused R36 to sustain 3 unobserved falls, with the 3rd fall causing emergent transfer to the hospital emergency room for treatment of head contusion, eye lacerations and nasal fractures. Findings include: R36 is a 55-year-old with diagnoses listed in part with epilepsy, seizure disorder, cognitive communication deficit, hemiplegia and diabetes. Two facility fall assessments dated 11/4/21 and 11/24/21 were conducted by V5 (RN) with both	S9999		

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S9999	Continued From page 2	S9999		

assessments showing R36 to be at high risk for falls.

A facility accident/incident form dated 11/3/21 written by V2 (Director of nurses) read, "Resident had a fall in the bathroom. The nurses went to the bathroom and resident was on the floor leaning up against the wall. Resident stated that he was trying to transfer himself, but he fell over his footrest."

R36's MDS (Minimum Data Set) dated 1/15/22 showed R36 needing maximum assistance with a minimum 1-person physical assistance for bathing, toileting, dressing, and personal hygiene.

A facility accident/incident form dated 11/24/21 written by V2 showed, "Writer observed resident on left, side-lying position, on floor in the small dining room. Writer assessed resident, bruising and swelling noted to the left upper eyebrow area." Resident stated, "I was leaning forward in the wheelchair and my foot slipped off the footrest, then I fell out of my wheelchair. " Orders received to send to hospital ER for evaluation."

On 3/14/21 at 10:55 AM, R36 was observed awake in bed with bilateral side rails up. R36 appeared alert and oriented and was conversive. R36 had a visible redness and swelling to his left eyebrow and was asked what had happened to him. R36 responded, "I fell while I was trying to get something from the refrigerator (pointing to the refrigerator placed atop a dresser drawer). That fell down when I reached for something in it, and I fell forward, and I broke my nose." Surveyor asked if the refrigerator fell on him, R36 stated, "I don't know, I just know it fell and I fell forward out of my wheelchair and then I went to the hospital and I got stitches and a broken nose, and it really

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S9999	Continued From page 3 hurt." On 2/24/22, R36 sustained another unsupervised fall. Hospital Emergency Department records showed: "02/24/2022 11:39. Patient presents after fall at his nursing home. Says he was reaching into his refrigerator, and he fell forward when his wheelchair moved, hitting the left forehead right above his left eyebrow. Visit diagnoses: 1. Forehead contusion, 2. Eyebrow laceration, 3. Fracture of nasal bones, 4. Maxillary sinus fracture, 5. Dizziness." On 3/14/21 at 11:15 AM interview with R36's nurse V5 (RN) stated, "(R36) is a fall risk. He is a left side hemi (hemiplegia) due to traumatic brain injury." Surveyor asked about R36's recent fall involving the refrigerator, V5 stated, "He (R36) was reaching for something inside his refrigerator, and he fell forward from his wheelchair. We put his fridge up higher on the dresser, so he doesn't have to bend down and fall over again." Surveyor asked if the refrigerator was secured to the dresser to prevent it from falling over, V5 stated, "The maintenance man is the one that placed it on top of there." Surveyor and another fellow surveyor inspected the refrigerator and showed it to be unsecured to a waist high dresser drawer. The refrigerator showed to easily tip over upon opening the refrigerator door and was not secured with any bolts or other mechanical device keep the refrigerator from tipping over. On 3/16/22 at 11:25 AM V7 (maintenance director) was asked about the refrigerator in R36's room. V7 stated upon interview, "I set up all the refrigerators in the room. They are normally provided by the family but there are some that the facility provides, I think. I generally place them on	S9999		

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S9999	Continued From page 4 the ground, and I put thermometers in them, so we (facility) are responsible for their maintenance and upkeep." Surveyor asked if refrigerators should be placed atop dresser drawers, V7 stated, "I normally would not put them on top of a dresser drawer due to safety because it could fall over and fall on someone." Surveyor asked if there were refrigerators on top of dressers, what precautions the facility would take, V7 stated, "I would probably ensure that it is secured to the dresser with something but otherwise I would not put it on top of a dresser." Surveyor asked if he placed R36's refrigerator on top of a dresser, V7 stated, "More likely I did because I install all of them, but I will have to see if it is secured." Calls to R36's physician made on 3/16 at 2:30 PM and 3/17 at 9:30 AM were left unanswered and with no return calls made to the surveyor. Facility policy undated policy titled "Facility Policy Regarding Resident Falls" reads in part, "This facility is committed to minimizing resident falls so as to maximize each resident's physical, mental, and psychosocial well-being. While preventing all resident falls is not possible, it is the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventative strategies, and facilitate as safe of an environment as possible. All resident falls will be assessed and the resident's existing plan of care will be evaluated for needed changes." (A)	S9999		