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 _____	05/18/2022

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 Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210a) 300.1210b) 300.1210c) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident's comprehensive assessment, which 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. (Section 3-202.2a of the Act) 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. 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 Regulations are not met as evidenced by: Based on interview and record review the facility failed to ensure fall prevention interventions were	S9999		

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S9999	Continued From page 2	S9999		

implemented for a resident at risk for falls for 1 of 28 residents (R59) reviewed for safety and supervision in the sample of 28. This failure resulted in R59 falling and sustaining a fracture of her femur that required surgical repair.

The findings include:

R59's Minimum Data Set Assessment dated 2/7/22 shows that her cognition is impaired and requires extensive assistance of two persons for toilet use.

R59's Fall Risk Evaluation dated 2/4/22 shows that she is at high risk for falls.

R59's Incident Report dated 3/13/22 at 8:50 AM shows that she had an unwitnessed fall in the bathroom.

R59's Incident Report dated 3/14/22 at 9:30 AM shows, "Resident was assisted to toilet, CNA (Certified Nursing Assistant) stepped out of room for 1 min (minute), nurse heard w/c (wheelchair) moved, observed pt. (patient) sitting on floor, back resting on toilet, w/c on left side, legs extended in front of her, continues with pain the LLE (Left Lower Extremity). Denies hitting her head, resident still needing care, was barefoot, no pants or brief, CNA coming back to give care.....Nurse asked her if she tried to walk to her bed she stated, "That's what I'm saying, help me go to bed, please, ma'am."

On 5/17/22 at 2:12 PM, V13 (Licensed Practical Nurse) stated that R59 fell and sustained a fracture. Since R59 has returned to the facility, she does not want to move and requires a mechanical lift for transfers.

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S9999	Continued From page 3 On 5/17/22 at 2:24 PM, V14 (Restorative Nurse) stated that she is not sure what interventions were put in place after R59's fall on 3/13/22 to prevent future falls. V14 stated that if a resident has had a fall in the bathroom, the staff should not leave them alone in the bathroom in the future to prevent any future falls. V14 stated that R59 was at risk for falls before her fall on 3/13/22. V14 stated that maybe the CNA was not aware that she fell the day before in the bathroom. V14 stated that if a resident is at risk for falls and is left unsupervised in the bathroom, they could fall. On 5/18/22 at 10:35 AM, V14 stated that a person who is confused and has a history of an unsafe self-transfer should not be left in the bathroom alone. R59's left femur x-ray from 3/15/22 shows that she had an acute spiral fracture of the distal femoral shaft with proximal/medial displacement. R59's Hospital Notes dated 3/15/22 shows, " [R59] is an 85-year-old female with Dementia-who presented to the emergency room earlier this afternoon after a fall at her nursing facility onto her left side. She was brought to the ER (Emergency Room) with severe pain and unable to ambulate....Assessment/Plan: Closed left distal femur fracture....consulted ortho trauma....surgery tentatively scheduled for 12:30 PM....." R59's Physician's Notes dated 3/28/22 shows, 'A few weeks ago patient had a fall complicated by right hip/leg pain; she was sent to the ER, and she was diagnosed with right femur fracture; patient was seen by ortho, and they treated her with IMN (Intramedullary Nailing). Since coming back, patient has been sleepier, and her appetite	S9999		

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S9999	Continued From page 4 has declined; she spends most of her time in the bed..." R59's Fall Care Plan shows that she is at risk for falls related to cognitive loss, alteration in endurance, impaired balance, incontinence, weakness and closed spiral distal femur fracture with proximal medial displacement, history of falls, not always cooperative with staff, unaware of her own risk factors and is dependent on assist from staff to complete bed mobility, transfers and locomotion. No fall interventions were added to her care plan after her fall on 3/13/22. The facility's Fall Reduction Program revised on 4/12/21 shows, "Safety interventions will be determined and implemented based on the assessed, individualized risks and in accordance with standards of care; interventions to be documented within the resident's care plan. Assigned nursing personnel are responsible for ensuring that the ongoing precaution(s) are put in place and consistently maintained per the individuals plan of care....Attempts shall be made to implement new or modified interventions as needed to enhance safety and consistent with root cause analysis; new interventions to be communicated to the facility staff through revision of resident care plan on profile to maintain continuity of care....Residents who require staff assistance will not be left alone after being assisted to bathe, shower or toilet if resident is not able to maintain proper sitting balance or determined to be at risk of unassisted transfer." (A)	S9999		