Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006266	A. BUILDING: ___ B. WING ___	05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONMOUTH NURSING HOME	117 SOUTH I STREET MONMOUTH, IL 61462

(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 Facility Reported Incident of 5/16/22/IL147067	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.1220b)2) 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 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. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. These Requirements were not met evidenced by: Based on interview and record review, the facility	S9999		

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Continued From page 2

failed to accurately assess a high risk resident's fall risk on admission and failed to implement interventions to prevent further falls for one of one resident (R1), reviewed for falls, in a sample of three. These failures resulted in R1 sustaining multiple falls with injuries, including a subarachnoid hemorrhage and fractures of the right lateral orbital wall/maxillary sinuses.

FINDINGS INCLUDE:

The (undated) facility policy, Fall Risk Assessment Guidelines and Fall Prevention, directs staff, "The Fall Risk Assessment is utilized to determine if a resident is at risk for a fall. The assessment tool (Morse Scale) will identify those residents at risk and will trigger nursing interventions to be implemented in the plan of care. The Morse Scale will be completed by the nurse on admission. The Morse Scale findings will be incorporated into the nursing plan of care upon formulation. Nursing interventions should be instituted based on findings and level of risk. Those residents scoring high on the Morse Scale will have hourly rounding during the day and every two hours at night. The resident is identified as risk for falls when the assessment yields a score of 25 or above."

R1's Hospital History and Physical, dated 4/26/22 documents, "(R1) was admitted to (Hospital Swing Bed) for physical deconditioning. She was originally admitted to acute care on 4/17/22 due to a urinary tract infection with diffuse weakness and deconditioning. She has a history of falls and cognitive impairment that affects her safety awareness. At this time (R1) is seated in a chair with an alarm and the call button within reach. Safety Interventions include: Assistive Device, Non-skid slippers/shoes when out of bed. Chair

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S9999	Continued From page 3 Alarm active and audible." R1's current facility Face Sheet documents that R1 was admitted to the facility on 5/4/22 with the following diagnoses: Urinary Tract Infection, Weakness, Fracture of the Lower End of the Right Radius, Acute Kidney Failure, Chronic Kidney Disease, Type 2 Diabetes Mellitus, Rheumatoid Arthritis, Chronic Congestive Heart Failure, Pulmonary Fibrosis and Anxiety. R1's facility Admission Fall Risk Assessment, dated 5/4/22 and completed by V6/Licensed Practical Nurse documents, "(R1) has no history of falls. Score = 8, Low Risk." R1's Admission Care Plan, dated 5/5/22 includes the following Focus areas: (R1) is at risk for falls D/T (Due To) being unsteady 2nd (Secondary) to dizziness. Also included are the following Interventions: Be sure (R1's) call light is within reach and encourage her to use it for assistance as needed. R1's facility Fall Investigation, dated 5/8/22 at 8:00 A.M. documents, "(R1) attempted to put socks and shoes on herself. After (R1) had put both shoes on, (R1) attempted to stand up unassisted and slid out of bed . (R1) had no injuries noted and was able to do all ROM (Range of Motion). (R1) stated she was attempting to get into chair for breakfast when her foot slid out from underneath her. Immediate Action Taken: (R1) was educated on the importance of waiting for staff to assist before getting up. Placed (R1's) call light within reach and reeducated this resident (R1) on the purpose of the call light system." R1's facility Fall Investigation, dated 5/10/22 at 11:00 A.M. documents, " Called to (R1's) room by	S9999		

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S9999	Continued From page 4 another nurse. (R1) was lying on the floor with head towards the window and one foot on the bed. (R1) was sitting in her recliner, which sits directly by her bed at the time of the fall. (R1) did not have on proper footwear and call light was on her bed, out of reach. (R1) was assessed for injuries and no injury or redness noted. (R1) was put on neuros (Neurological Checks). (R1) was assisted off the floor by staff and vitals (Vital Signs) were taken. (R1) was educated on proper foot wear and staff was educated on making sure call light is within reach at all times." R1's Medical Record, dated 5/11/2022 at 1:31 P.M. documents, "Health Status Note Text: This nurse was sitting at nurse's desk and heard a dish fall to the floor. At that very moment, a resident sitting in front of nurse desk hollered, 'Hey someone is on the floor, someone fell'. This nurse got up to see what was going on and saw (R1) lying face down on the floor in the hallway. (R1) was facing away from the wall with the right side of (R1's) face on the floor and on top of her right hand and arm. This nurse hollered for DON (V2/Director of Nursing) to get assistance. Once I got to resident, (R1) had blood coming from head area and was unresponsive for a couple of minutes. Once (R1) came to, she was attempting to move. (R1) was not answering questions appropriately at first but when she started to get her mind together, she was alert and oriented. Multiple staff came to assist (R1) and assess for injuries. DON was on floor attempting to talk to (R1) and to see where the blood was coming from. Vitals were taken, 911 was called. POA (Power of Attorney) was notified of incident. Once ambulance arrived, (R1) made motion as though she was going to vomit. (R1) did throw up a bit of blood. Noted a hematoma on the right temporal region and blood noted coming from the nose.	S9999		

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S9999	Continued From page 5 Once returning to facility, resident's room will be moved closer to nurse's desk. Neuros (Neurological Assessment) initiated and pupils sluggish but equal and reactive. Moving all ext (extremities) and denies pain at time of transfer." R1's Emergency Room History and Physical, dated 5/11/22 at 12:05 P.M. documents, "(R1) presents to the emergency department for a ground level fall. (R1) was recently discharged to (the facility) after a hospital stay for UTI (Urinary Tract Infection). (R1) fell in the hallway causing head injury and positive loss of consciousness. (R1) is on blood thinners. (R1) admits to headache, but denies other pain. CT (Computerized Tomography) of Brain-Impression: Right frontal/parietal and temporal convexity subdural hematoma. Right lateral orbital wall/maxillary antral fractures. ED Course: (R1) has acute subdural hematoma. (R1) also has some orbital fractures. Discharge to (Regional Trauma Center)." R1's Hospital Trauma Surgery Discharge, dated 5/15/22 documents, "(R1) was admitted for further evaluation and treatment of injures. Plastic surgery was consulted for evaluation of facial fractures with recommendations for conservative management and avoiding nose blowing. Neurosurgery was consulted for evaluation with imaging showing subdural hematoma and subarachnoid hemorrhage.(R1) was given Kcentra (Prothrombin Complex Concentrate) and monitored in the Intensive Care Unit. Neurosurgery recommends holding all anticoagulants and aniplatelets until seen in follow up in the office. (R1) was discharged to (the facility) in stable condition. Fall risk precautions."	S9999		

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S9999	Continued From page 6 R1's Medical Record documents, "5/15/2022 at 10:30 P.M. (R1) returned to facility via ambulance stretcher from (Regional Trauma Center) at this time. (R1) oriented to new room and call system and will be monitor closely. (R1) alert with intermittent short-term memory deficit observed. (R1) placed in bed for comfort. Bruising noted to left arm and facial bruising and right outer thigh bruising." R1's facility Fall Investigation, dated 5/16/22 at 5:40 A.M. documents, "(R1) found on floor immediately after hearing a noise. (R1) was at the foot of the bed, on the floor. No complaints of pain. (R1) assessed for injuries, small skin tear to left arm, small knot on back of right head. Neuro assessment done and normal. Assisted off floor by two staff, instructed (R1) to use call light for assistance. Phone call placed to (V2/Director of Nurses) with instructions to monitor neuros closely and to make frequent rounds on resident to prevent another incident." R1's Medical Record documents, "5/16/2022 at 6:15 A.M., (R1) has c/o (Complaints Of) of severe headache and was dry heaving. Nurse assessed (R1) and (R1) unable to take Tylenol due to nausea. (R1's Physician) and HCPOA notified, and orders received to transfer resident to (Local) E.R. for eval (Evaluation) and treat of headache and nausea. Other Neuros remain intact." R1's Emergency Room Triage Note, dated 5/16/22 at 8:24 A.M. documents, "(R1) is resident at (Facility) and returned there yesterday at 10:40 P.M. after discharge from (Regional Trauma Center) post-fall last week with sub arachnoid hemorrhage. (R1) tried to get up today without assist and had an unwitnessed fall at approximately 5:30 - 5:45 A.M. (R1) has bruising	S9999		

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S9999	Continued From page 7 to right hip, right periorbital area and right forearm with a small skin tear on forearm. All appear to be older except for the skin tear. Upon arrival (R1) is denying any pain. (R1) does have some vomit on front of gown. CT of Brain: Interval increase in thickness and acute hyperdense component of right cerebral convexity, careful seen, and right greater than left tentorial subdural hematoma. Secondary to mass effect, there is a 6 MM (Milliliter) left midline shift. Right parietal scalp contusion and subgaleal hematoma has increased in size. Transfer to (Regional Trauma Center)." On 5/23/22 at 10:20 A.M., V2/Director of Nurses (DON) stated, "(R1) had a history of falls. (R1) was admitted to us from a local hospital on 5/4/22 for continued therapy, due to multiple falls. (R1) was to be a short term rehab stay. When a resident is admitted, we do a Fall Risk Assessment. Depending on the score, we have different interventions to put in place. We have low beds and fall mats and bed (pad) alarms in the facility and we also have floor beds. Sometimes we put a resident in a recliner and place them at the Nurse's Station, so we can keep a closer eye on them. (R1) fell on 5/8/22 when she slid out of bed. Staff was educated to keep her call light close to her at all times and we educated (R1) to use her call light when she needed assistance. (R1) fell again on 5/10/22 when she was found laying on the floor, next to her bed. (R1) had been sitting in her recliner. (R1) did not have on proper foot wear and her call light was on her bed, out of her reach. Staff was reeducated to place her call light within reach and to make sure (R1) was wearing non slip footwear. We did not place an alarm on (R1). On 5/11/22 (R1) fell while ambulating to the kitchen and sustained a head injury. (R1) was admitted to the	S9999		

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hospital. The new intervention was to move (R1) closer to the nurse's station when (R1) returned from the hospital. (R1) came back on 5/15/22." We did not put (R1) in a low bed or use a bed (pad) alarm for (R1), or fall mats."

On 5/23/22 at 10:39 A.M., V4/Registered Nurse (RN) stated, "We got (R1) back from the hospital around 10:30 at night on 5/15/22. (R1) was extremely confused and combative. By 10:45 PM, (R1) had already gotten herself out of bed and was found standing in her room. We tied (R1's) call light around her wrist and put (R1) back to bed. (R1) did not have an alarm on. (R1) was not in a low bed. We did not put (R1) in a recliner and put (R1) within sight at the nurse's station. That's what we were going to do the next time (R1) fell. Around 5:45 the next morning we heard a noise and we found (R1) at the foot of the bed, on the floor. (R1) had a small skin tear on her left arm and a small knot on the back of her head, on the right side. It was right at shift change. I called (V2/DON) who told me to monitor (R1's) neuro (neurological) signs and to make frequent rounds on (R1). I told the day shift, I would put (R1) in a recliner and set her at the Nurse's Station, if it were me. I filled out the reports and left after that. When I left, (R1) was still here."

On 5/23/22 at 11:05 A.M., V3/Assistant Director of Nurses (ADON) stated, "If someone is at high risk for falls, we can place that resident in a low bed with fall mats or use a bed (pad) alarm to alert staff. (R1) did not have a low bed, or fall mats or a bed alarm."

On 5/23/22 at 12:41 P.M., V5/Licensed Practical Nurse (LPN) stated, "When (R1) came to us, (R1) had a history of falls. (R1) was definitely at high risk for falls. (R1) did not have a low bed or fall

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S9999	Continued From page 9 mats or a bed alarm. On 5/11/22, around 11:00 AM, I was charting at the nurse's desk and another resident sitting by the desk, looked down the south hallway and said, 'Hey, somebody fell.' At that same time, I heard a dish break on the floor. Evidently (R1) was walking down the hall, by herself, to return a dish to the kitchen and (R1) fell flat on her face. When I got to (R1), the right side of (R1's) face was laying on the floor. (R1) was bleeding from her nose. We immediately called 911 and sent (R1) to the E.R. (Emergency Room). I also worked the morning (R1) fell on 5/16/22. (R1) wasn't my patient. All I was involved in was copying papers and calling 911 to send (R1) to the hospital. It was around 7:10 when we sent (R1) in." On 5/23/22 at 12:51 P.M., V6/Licensed Practical Nurse (LPN) stated, "I was the nurse who completed (R1's) Fall Risk Assessment. I didn't know (R1) had fallen prior to (R1's) admission. We didn't always have the paperwork, when we admit someone. If I had know that, it would have changed (R1's) fall risk and interventions." On 5/24/22 at 10:57 A.M., V7/Registered Nurse (RN) stated, "When I came into work on 5/16/22, (R1) had fallen again. I went to (R1's) room after I had gotten report and (R1) was in bed and yelling that her head hurt and she wanted some Tylenol. When I returned with the Tylenol, (R1) began retching and eventually vomited some bile. At that point I didn't feel comfortable giving (R1) anything, so I called the doctor and requested to send (R1) to the hospital. The other nurse called 911 and I sent (R1) to the (local) E.R." (A)	S9999		