STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005631	A. BUILDING: _____ B. WING _____	C 05/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYVIEW CARE CENTER-MACOMB	400 WEST GRANT STREET MACOMB, IL 61455

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S 000	Initial Comments Facility Reported Incident Investigation of 5/15/22/IL147338	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.690b) 300.690c) 300.1210b) 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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 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	S9999		

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S9999	Continued From page 2 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. Restorative measures shall include, at a minimum, the following procedures: 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, 1) the facility failed to ensure a resident assessed to be at high risk for falling was wearing proper footwear and 2) Based on record review and interview, the facility failed accurately summarize a written fall investigation and report all necessary findings to the State agency for one resident (R1) reviewed for falls. 1) This failure resulted in R1 slipping on the floor as she was getting out of bed and experiencing a fall resulting in a fractured finger on her right hand and a laceration to the back of her head which required staples. Findings include:	S9999		

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S9999	Continued From page 3 The facility "Fall Prevention" policy, revised 11/10/18, documents that the facility is responsible, "To provide for resident safety and to minimize injuries related to falls, decrease falls and still honor each resident's wishes/desires for maximum independence and mobility." On 5/26/22 at 11:40 am, R1 was in the dining room being fed lunch by staff. R1's right and left forearms were in a hard cast, which is why R1 needed feeding assistance. A Fall Risk Assessment, dated 3/09/21, documents R1 scored a 17, which indicates a high risk for falling, related to occasional confusion, use of psychotropic, anti-seizure and diuretic medication, and the diagnoses of Parkinson's Disease, Seizure Disorder, Mental Illness and Cognitive Deficit/Dementia. R1's Minimum Data Set assessment, dated 3/08/22, documents R1 has significant cognitive impairment, requires extensive assistance of one staff member to dress, and has experienced three or more falls since the last quarterly Minimum Data Set assessment. R1's current Plan of Care (no date), documents R1 is high risk for falling and instructs staff, "Observe for unsteady/unsafe transfer or ambulation and provide stand by or balance support as needed" and to have R1, "wear non-skid socks during (hours of sleep)." A Fall Investigation Report, dated 5/15/22, documents R1 was in the dining room at 3:00 pm and fell from her wheelchair attempting to reach for or transfer to a chair. Staff were present in the dining room, but unable to prevent R1's fall. R1 complained of left wrist pain on assessment	S9999		

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S9999	Continued From page 4 and the Physician ordered a portable x-ray to be completed at the facility. The x-ray revealed R1 had sustained a fracture of the left distal radius and R1 was sent to the hospital. All of R1's falls over the last six months were reviewed. Documentation of a previous fall, on 5/01/22, indicates R1 fell in her room and broke a finger on her right hand. An "A.I.M. for Wellness" report, dated 5/01/22 (no time), documents R1 fell and, "(R1) had a 2 cm (centimeter) laceration to back of (R1's) head on the left side. Pressure was held to area. (R1) is complaining of pain to her right hand. (R1) was sent to the ER (Emergency Room) by ambulance for evaluation." A Hospital Diagnostic Radiology report, dated 5/02/22, documents R1 sustained the following: "Fracture through the neck of the second metacarpal with slight displacement along the medial aspect." A Physician's Report, dated 5/11/22, documents R1's right hand and arm were placed in a hard cast during an Orthopedic Consult due to the right hand second metacarpal neck fracture. A "Fax Worksheet (State Agency) Form," dated 5/01/22, documents at 11:45 pm, R1, "reports when was getting out of bed to go to breakfast and slid, related to not having on proper footwear, nurse viewed resident on the floor on her back under the bedside table. Laceration noted to posterior scalp. Sent to ER for (evaluation and treatment). (R1) discharged from ER with 2 staples to posterior scalp and new orders to remove staples in 7-10 days. Monitor laceration for infection and keep clean and dry. Husband aware and agreeable to plan of care. (R1) encouraged to sleep in non-skid socks for safety and increase staff supervision during hours of	S9999		

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S9999	Continued From page 5 sleep." This final notification of findings to the (State agency) fails to report that R1 sustained a right metacarpal neck fracture. On 5/29/22 at 3:02 pm, V6 (Licensed Practical Nurse) stated she was at the nurses station on 5/01/22 and heard a noise from the hallway. V6 stated she immediately started checking rooms and found R1 lying on the floor of her room. V6 stated R1 was bleeding from her head and was complaining of pain in her right hand, so she sent R1 to the Emergency Room. V6 indicated R1 should have had slipper socks put on before she was put in bed, because R1 is very unsteady on her feet and wants to be independent with ADLs (Activities of Daily Living). On 5/26/22 at 2:48 pm, V2 (Director of Nursing) stated she conducted the investigation into R1's 5/01/22 fall and confirmed that R1 sustained a scalp laceration and fractured finger as a result. V2 stated she determined that at the time of the fall, R1's feet were bare when she should have had slipper socks, as identified in her plan of care. V2 concluded that R1 requires assistance to dress and would have needed help from staff to put on non-skid socks before bed. V2 stated she did not inform the Regional Office in her reportable findings regarding R1's 5/01/22 fall that R1 sustained a fracture, even though that information was known on 5/02/22 upon R1's return from the Emergency Room, and that information should have been included in the report. (B)	S9999		