STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000210	A. BUILDING: _____ B. WING _____	C 01/09/2024

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ACCOLADE HEALTHCARE DANVILLE	801 NORTH LOGAN AVENUE DANVILLE, IL 61832

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S 000	Initial Comments Complaint Investigations: 23610752/IL168169 2460065/IL168351	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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. 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	S9999		

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S9999	Continued From page 1 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 requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a safe, functional air mattress to prevent a fall from bed; failed to thoroughly investigate the environment to determine a targeted root cause to repair or replace the air mattress for R2. These failures resulted in R2 sustaining a head injury and laceration requiring emergency medical care at a local hospital. R2 is one of five residents reviewed for accidents/accidents on the sample list of 11. Findings Include: 1.) R2's "Admission Record" documents R2's initial admission date as 11/20/23. It includes the following diagnoses for R2: "Diffuse Traumatic	S9999		

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S9999	Continued From page 2 Brain Injury with Loss of Consciousness Unspecified Duration, Subsequent Encounter 6/23/23, History of Falling 6/23/23, Post concussion Syndrome dated 11/13/23, Idiopathic Normal Pressure Hydrocephalus 11/13/23 and Ataxia 11/13/23, and Weakness 10/01/23". R2's Skin/Wound Note dated 11/20/2023 at 4:19 pm documents the following: "Note Text: Resident is a new admit today. Skin assessment complete. Resident has multiple pressure injuries to bilateral feet/heels, and a pressure injury to her left hip and ischial tuberosity. See wound rounds for full assessments. Resident is on a low air loss mattress; she has contractures to both legs in which she keeps her legs up in a fetal position. Resident does moan in pain when providing care. Will verify that resident has pain medication ordered. Resident also has a g-tube (gastrostomy feeding tube) noted as well and a PIV (Peripheral Venous Intravenous) noted in the left forearm. Areas to feet were swabbed with betadine and left OTA (open to air). Areas to hip were cleansed and a Duoderm applied. Will Consult (V38, Wound Physician)." R2's Minimum Data Set dated 11/27/23 documents, R2 had moderate cognitive impairment, one upper and both lower extremity impaired range of motion and required substantial/maximal assistance bed mobility to role from back to side. R2's Care Plan dated 11/20/23 documents: "(R2) has an ADL (activity of daily living) selfcare performance deficit r/t (related/to) Confusion, Traumatic Brain Injury, Osteoarthritis, and Post-concussion Syndrome. BED MOBILITY: The resident requires extensive assistance x2 (of two)	S9999		

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S9999	Continued From page 3 staff to turn and reposition in bed per facility protocol and as necessary. TRANSFER: The resident requires full mechanical lift, large sling, and 2x staff to move between surfaces as necessary." The same Care Plan documents: "(R2 is high risk for falls r/t Confusion, Deconditioning, New Admission." R2's Nursing Note dated 11/24/2023 at 09:45 am signed by V3, Licensed Practical Nurse (LPN) documents the following: "Note Text: Alerted to (sic) fall by RA (V27, Hall Assistant). Upon entering the room, resident was noted to be laying on her right side between her bed and the window. Full body assessment completed approx. 1 (one) inch laceration noted to resident's right forehead, bleeding copiously (large quantity). Pressure dressing applied to stop bleeding. EMS (Emergency Medical Service) called for transport." The same note documents a report called to the local hospital emergency department. R2's "ED (Emergency Department) Progress Note" dated 11/24/23 documents the following: " Chief Complaint, Pt (patient) presents with Laceration." The "ED (Emergency Department) Progress Note" documents: "Pt presents to the ED by EMS for head laceration after a falling out of her bed at the nursing home. Patient has significant health history as well as history of TBI (Traumatic Brain Injury). Bleeding is controlled on right forehead laceration." The "ED (Emergency Department) Progress Note" documents: "Patient is severely contracted."	S9999		

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S9999	Continued From page 4 The "ED (Emergency Department) Progress Note" documents R2 required laboratory test and a Computed Tomography (CT scan) diagnostic imaging of R2's head. R2's CT results document R2 sustained "a small scalp hematoma in the right frontal region measuring approximately 2.5 centimeters width and 4.4 millimeters in the AP dimension (front to back)." "Clinical Impression: Fall: Acute, Laceration of Head, Acute, Leukocytosis Unspecified Acute, Thrombocythemia, Acute, Anemia, Unspecified." Leukocytosis Unspecified, Acute." R2's right forehead laceration was cleaned; blood controlled a pressure dressing was applied and R2 was transferred back to the facility". On 01/04/24 at 1:30 pm V27, Hall Assistant stated V27 was down the hall passing water to the residents. R2 was not in her bed. V27 saw R2 on the floor. V27 came out and reported to a V14 LPN. V14 and another nurse (unidentified) came to the resident room. They went in and examined her. "Some CNAs (unidentified) went in to help (R2) first." (V27 did not recall if the mattress was deflated." On 01/04/24 at 3:15 pm V3, LPN stated V3, LPN was R2's nurse when R2 fell 11/24/23. V3 stated R2's air mattress was already deflated when V3 got to her room. V3 stated, "It had happened before, where the cord was pulled out of the socket." V3 stated "She (R2) was very contracted and did not generally move much in bed, and for sure could not role over on her own." On 01/5/24 at 9:25 am V2, Director of Nursing	S9999		

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S9999	Continued From page 5	S9999		

(DON) stated, "(R2) was in a low bed with a low-air flow mattress. She (R2) could become fidgety when in bed. Though, I had never seen her roll on her own. I was told she rolled out of bed. I don't know if (R2) had side rails. Likely, not since she had an air mattress. I did not check to see if her air mattress was inflated. My investigation should have covered these (air mattress and side rails) as part of the environment assessment. I could have been more thorough. Her fall was not witnessed. I think it was just assumed she rolled on her own, since she was found on the floor next to her bed. I don't recall any staff reporting issues with the mattress. (V21, Certified Nursing Assistant) would have been the last CNA to do bed check and reposition (R2)."

On 1/5/24 at 10:14 am V17, Licensed Practical Nurse (LPN) stated, "I V17 could not figure out how (R2) she fell out of bed. She did not hardly move when I saw her on my shifts. She could not roll without assistance. I worked several shifts before her fall when CNA's (unidentified) reported (R2's) air mattress was deflating. They would alert me. I would assess the mattress. I found her air mattress was not plugged in. The first time it happened I could not figure it out for several minutes. (R2) air mattress was never completely deflated but was deflating fast that night (first unidentified). After that, the plugs were the first place I checked each time the air mattress was deflated. It was not as far as it was that first time. I think (V34, and V35) have both reported (R2) mattress was not holding air. I think it was them. Not for sure. The first time it was (V18, CNA) pretty sure."

On 1/5/24 at 10:56 am V21, Certified Nursing Assistant stated, "(R2's) feet were wrapped. She

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S9999	Continued From page 6	S9999		

was in bed all the time. Therapy was just starting to work with her. (R2) did not roll in bed at all. She was small but it still took two people to reposition her. Her legs were very contracted, and she could not move them at all on her own. She would lay in a fetal position. When we would reposition her, she was always in the same fetal position we left her in. She did not like to be touched. We had to be very easy with her. She could move her arms a little and would put her hands down by her depends on when we changed her. I did have her mattress deflate a couple times. It was never all the way deflated but it was obvious it was not staying plugged in. I started checking the plug when I would come on my shift."

On 1/5/24 at 12:55 pm V30, Certified Nursing Assistant stated, "(R2's) Air Mattress was problematic and reported several times to nurses before she fell. It was an agency nurse. I can't remember her name. Pretty much when I would come in to work, (R2's) mattress would be deflating. Twice it was almost totally deflated. Several times it was partially deflated. It was not the plug. It was the hose attached to the air mattress machine, at the foot of (R2's) bed. The hose would be pulled away where it is supposed to attach. If not attached tight, the air did not go into the mattress like it was supposed to. Her bed was always in the low position. (R2) could not roll by herself. Rarely would she even move. We needed two people to reposition her and change her. She had contracted legs, so I know she had not knocked the hose off the machine herself. My guess is the hose detached with staff rolled her to do peri-care. I was not here the night (only fall occurred on day shift 11/24/23) she (R2) fell. I do know if the air mattress was a problem before that fall. I know I had warned the nurses before that she was going to fall. It was just a matter of

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S9999	Continued From page 7 time. I also told them we needed to put floor mats down. That did not happen until after she fell." On 1/5/24 at 3:09 pm V36, Certified Nursing Assistant (CNA) stated, "I was the first person in the room after (R2) fell. The Hall Aide (V27) said she (R2) fell. Hall Aides can't give any kind of care to the residents. She just let us know when someone needs something. (R2's) mattress was deflated. We had problems with that mattress deflating all the time. Everybody knew it. It was reported a couple of times by me, and I know by other CNA's (unidentified) too. (R2) was on the floor with her head bleeding. Two CNA's, (V21 and V31) came in right after me. Then I think it was (V3, LPN), (V14, LPN) and (V15, RN wound Nurse). (R2) could not change position on her own. She barely moved from one bed check to the next. The whole two hours between, she was always where we left her." On 1/5/24 at 3:15 pm V31, CNA stated, "I saw (R2's) mattress when she fell. It was mostly deflated. (R2's) air mattress deflated many times. It had a short in the cord. It would go off and on. We knew it for several days. We had to move the cord to get it inflated. When she fell, I don't think she rolled but that is what they said was the caused the fall. That didn't make sense because she never changed positions on her own. She just laid in a fetal position all the time." R2's "Fall" investigation did not document R2's air mattress was assessed as part of the environmental review. The root cause was documented as R2 rolled out of bed. Therefore, R2's Care Plan dated 11/20/23 documents the post-fall 11/24/23 intervention was a fall mat next to bed. The care plan does not document a targeted intervention related to R2's air deflated	S9999		

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S9999	Continued From page 8 air mattress. A facility "Work Order" list dated 11/20/23 at 12:49 pm documents: "(R2's room-bed number) needs air mattress" and work order was completed. On 01/5/24 at 8:20 am V32, Maintenance Department provided the above work order. V32 stated V32 has had no work orders indicating R2 air mattress needed repaired or replaced. (A)	S9999		