STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001531	A. BUILDING: _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

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S 000	Initial Comments Complaint investigation 2452778/IL171719	S 000		
S9999	Final Observations Statement of Licensure Violations. 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The	S9999		

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

Electronically Signed | 05/10/24

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S9999	Continued From page 1 facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. This requirement was not met as evidence by: Based on interview and record review the facility failed to notify a resident's physician for a fall with injury in a timely manner for one of three residents (R1) reviewed for falls in a sample of 7. This failure resulted in delayed treatment for R1's impacted distal radius fracture and ulnar styloid fracture of the right wrist.	S9999		

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S9999	Continued From page 2 Findings included: According to R1's Admission Face Sheet and Cumulative Diagnosis sheet, R1 was admitted to this facility on 12/7/2022 with the diagnoses of Severe Dementia associated with Alcoholism without behavioral Disturbance, Psychotic Mood Disorder, and Anxiety. R1's MDS (Minimum Data Set) dated 12/18/2023, documented an attempt to assess R1 using the BIMS (Brief Interview for Mental Status) test, but R1 was unable to perform the test due to rarely or never understood and thus had no score out of 15 total indicating R1 has severe cognitive impairment. This same MDS documented R1 is independent with walking, transferring, does not use a wheel chair and has no impairment to upper and lower extremities. On 4/11/2024 at 9:22am, V6 (Certified Nursing Assistant/CNA) said on 3/31/2024 she was working R1's unit the evening R1 fell out of bed. V6 said at around 10:00pm, she was up at the nurses station, which is close to R1's room, when she heard a loud thump and went to check on R1. V6 said she found R1 sitting on the floor next to her bed. V6 said R1 told her she was ok so she helped R1 back into bed and went to report the fall to the nurse (V5) and V5 came to see R1 immediately. On 4/11/2024 at 8:45am, V5 (Licensed Practical Nurse/LPN) said on 3/31/2024, she and V6 were working on R1's hallway when R1 fell out of bed and hurt her right wrist. V5 said she assessed R1 and did not find any injuries to R1's body except R1's right hand/wrist was very bruised and swollen. V5 said she contacted R1's family to report the fall and injury. V5 said she tried to contact R1's doctor all night, but did not get an	S9999		

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S9999	Continued From page 3	S9999		

answer. V5 said she did not send R1 to the local emergency room and thought the next shift (day shift) would notify the doctor of R1's fall and injury to right wrist/hand and get treatment for R1.

On 4/11/2024 at 11:26am, V11 (LPN) said she worked the dayshift on 4/1/2024 and 4/2/2024 but did not remember being told in report about R1's fall and right wrist/hand injury, bruising and swelling and thus did not continue to attempt to notify R1's doctor on either day. V11 said it is so hectic and loud on the dementia unit that she has trouble concentrating. V11 said the facility was not short staffed and she feels adequately trained, but has only worked at this facility for about 3 months. V11 said on the morning of 4/1/2024, R1 came to her and showed her the injured wrist, but V11 did not catch what R1 was trying to tell her. V11 said on 4/2/2024 at 12:00pm, during the noon meal, V18 (Social Service Director) was the first staff to notice R1's right hand was injured and asked V2 (Director of Nursing/DON) to take a look at it. V11 said she was too busy to contact R1's doctor until around 3:00pm when she sat down to chart at the nurse's station. V11 said at 3:00pm, she notified V14 (Nurse Practitioner) of R1's right wrist/hand injury with swelling and bruising.

A Social Service Progress Note in R1's medical record dated 4/1/2024 documented by (V18/Social Service Director/SSD) the following: Was told in morning meeting the resident (R1) had fallen out of bed. After morning meeting I sat down with resident in her room. She claims it doesn't hurt "Not really" is what she said. Couldn't explain what happened to me. Only said "It just happened yah know."

A Nurse's Note in R1's medical record and dated

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S9999	Continued From page 4 4/1/2024 (actual date of entry 3/31/2024) documented V5 called R1's doctor at 10:45pm, 11:20pm and on 4/1/2024 at 4:15am, but the doctor's phone continued to have a busy signal every time V5 called. A Social Service Progress Note in R1's medical record dated 4/2/2024 by (V18/Social Service Director/SSD) documented the following: Writer noticed residents (R1) Rt (right) arm bruised, hand/palm swollen. I (V18) reported this to DON (Director of Nursing-V2). She immediately when (sic) down to resident's room. Xray was ordered (mobile x-ray service name). After results was taken to ER (Emergency Room) Returned with temp (temporary) cast ... A Nurse's Note in R1's medical record entered by V2 (DON) on 4/2/2024 at 12:40pm documented the following: Request from SS (Social Services) to check residents R (right) arm, has bruising and R (right) hand palm is swollen. Resident c/o (complained of) pain when hand touched, but could not rate pain. Will contact NP (Nurse Practitioner). A Nurse's Note in R1's medical record entered by V2 on 4/2/2024 at 1430 (2:30pm) documented the following: Clarification of R (right) forearm discoloration. Dark bruising vertical marks with yellow discoloration around the wrist area. Palm of the hand is discolored also (dark). (R1) has no recall of hurting her arm. A Nurse's Note in R1's medical record by V11 (LPN) on 4/2/2024 at 3:00pm documented the following: Resident noted to have bruising at different stages to the R (right) wrist and to R (right) forearm. Notified mother who states res. (resident) has had a cast in the past and will not	S9999		

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S9999	Continued From page 5 leave it alone, that she will work it off. Notified provider (V14 /Nurse Practitioner) via (name of messaging service used to communicate with providers) with pictures ... A Nurse's Note in R1's medical record by V11 (LPN) on 4/2/2024 at 6:30pm documented the following: (mobile x-ray service providers name) personnel here (at facility) to do x-ray to R (right) forearm. The x-ray service provider results for R1 dated 4/2/2024 documented the following: Procedure-Right Forearm, 2 views, Findings-an impacted distal radial fracture is identified. The fracture does not involve the articular surface. An ulnar styloid process fracture is also noted. Moderate degenerative changes are present. The remaining osseous structures are intact. R1's ED (Emergency Department) Physician Documentation from the local hospital dated 4/3/2024 documented the following in part: This patient presents from the nursing home with diagnosis of an impacted distal radius fracture and ulnar styloid fracture of the right wrist. This was sustained in a fall yesterday. A Nurse's Note in R1's medical record by V5 (LPN) on 4/3/2024 at 4:40am documented the following: Rec'd (received) stat x-ray results #1 R (right) wrist fx (fracture), #2 R (right) forearm fx (fracture), #3 R (right) hand fx (fracture). A Nurse's Note in R1's medical record by V5 (LPN) on 4/3/2024 at 4:45am documented the following: Called (name of on call doctor) TO (telephone order) to send resident (R1) to ER (emergency room) for eval (evaluation) and Tx (treatment).	S9999		

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S9999	Continued From page 6 On 4/11/2024 at 12:39pm, V2 (Director of Nursing/DON) and V3 (Assistant DON) were interviewed at the same time and both agreed R1's doctor was not notified of R1's injuries and fall in a timely manner and that it should not have taken 2 days to begin providing R1 care of her injured right wrist/hand that was determined 2 days later to be a fractured right wrist. V3 said when R1's doctor could not be reached, V5 (LPN) should have sent R1 to the local emergency room for evaluation of her right wrist/hand injury at the time the injury was first discovered. V2 said V11 (LPN) should have continued to reach R1's doctor but failed to do so. V2 said the facility does not have a policy on what the nursing staff should do if they cannot reach the resident's doctor in a timely manner, but they will look into getting one. (B)	S9999		