

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012470	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/01/2024
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NAME OF PROVIDER OR SUPPLIER PITTSFIELD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 610 LOWRY STREET PITTSFIELD, IL 62363
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S 000	Initial Comments First Revisit to Annual Health Survey of January 2, 2024	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)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 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	S9999		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/08/24
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S9999	<p>Continued From page 1</p> <p>care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to thoroughly investigate falls and implement fall interventions as identified in care plan for 1 of 3 residents (R13) reviewed for accidents in the sample of 11.</p> <p>This failure resulted in R13 falling out of her chair and receiving hematoma to left front scalp, skin tears on left frontal scalp and temporal region, and cervical strain.</p> <p>Findings include:</p> <p>1. MDS (Minimum Data Set), dated 11/20/2023, documents resident is cognitively intact with a BIMS (Brief Interview of Mental Status) of 15.</p> <p>R13's Care plan, dated 11/15/2023, revised 1/30/2024, documents R13 is at risk for falling related to (urinary catheter), advanced age, history of falls, dx (diagnosis) of heart failure, hypertension. R13's care plan documents the</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>following interventions: 1/22/2024 remind resident to keep call light in reach at all times and call for assistance.</p> <p>R13's incident report, dated 1/22/2024 at 10:45PM, documents R13's roommate yelled that R13 was on the floor. R13's report documents R13 was on the floor with her upper left side of her head against the metal leg of a side table. R13's incident report documents R13 had elevated area on the upper left side of forehead with a laceration. Report documents another laceration noted to lower left forehead and area to left eye. R13's report documents moderate amount of blood noted. R13's report documents R13 stated she leaned forward to pick something up off of the floor and fell. R13's incident report documents R13 was sent to the hospital for evaluation and treatment. R13's incident report, dated 1/22/2024 at 1:24AM, documents progress notes from hospital emergency room documents CT (computer tomography) scan and CT scan cervical spine impression; hematoma left frontal scalp, skin tears left frontal scalp and temporal region, and cervical strain. R13's report documents to remind resident to use call light, and staff educated to keep call light within resident's reach at all times.</p> <p>On 1/10/2024 at 2:52PM, R13 was sitting in a wheelchair in her room facing the TV with bedside table in front of her. R13's Power recliner behind R13 was in a raised position. Surveyor could not see call light. R13 asked where her call light was. R13 stated "I don't know." Steri strips to left frontal skull. R13 stated she fell out of the chair. V66, Certified Nursing Assistant (CNA), was asked if V66, CNA, could show surveyor call light. Call light was wrapped around upper half bed rail on the left side of the</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>bed behind resident out of her reach. V66, CNA, stated R13's call light not within reach, and it should be in reach for R13.</p> <p>On 2/1/2024 at 11:25AM, V1, Administrator, and V14, interim DON (Director of Nursing) stated in-servicing had been done on all staff in regard to ensuring call light in place. V1 stated R13 fell out of her chair when bending over to get something and bumped her head, so that is why she was sent to the emergency room. Surveyor asked why R13 was up in her wheelchair at 10:45PM? V14, interim DON, stated, "I don't know if she stays up late or is one of those who gets her days and nights mixed up." V1, Administrator, stated R13 could have been in her wheelchair if R13 had been toileted. Both V1 and V14 stated they had not interviewed all staff in regard to R13's fall. V14 stated she had interviewed the nurse and R13's roommate for investigation of R13's fall.</p> <p>The facility fall policy, revised 4/3/2018, documents: 2. Check resident's ability to explain what happened; evaluate resident's condition before the fall. 3. Check if, or with anyone who witnessed the accident. Determine, if possible, where, how, and when the accident occurred.</p> <p>(B)</p>	S9999		
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