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
	IL6015895	A. BUILDING: ______ B. WING ______	11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR HEALTH CARE	**485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263**

(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 Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b)5) 300.1210d)6) 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/09/19

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nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to provide 1) the identified level of assistance needed for safe transfers and 2) failed to correctly apply roll-control bolsters for fall prevention for 2 residents (R59 and R329) reviewed for accidents. This failure resulted in R329 falling in the shower room during a transfer and sustaining a tibial fracture.

The Findings Include:

1. R329's admission record documents an initial admission date of 5/31/15 and includes the following diagnoses: unspecified fracture of the upper end of left tibia, left artificial hip joint, major depressive disorder and history of falling. R329's quarterly Minimum Data Set (MDS) dated 7/8/19, documents a BIMS (Brief Interview of Mental Status) score of 8, which indicates moderate cognitive impairment.

On 11/19/19 at 11:00 AM during initial tour, R329 was alert and oriented to person, place and time, and stated that he had been dropped in the shower and broke his leg a little while ago. R329 was observed at this time in his wheelchair with his left leg in an immobilizer.

An event report documents that R329's fall was witnessed, occurred on 8/20/19, and was reported to the nurse at 10:30 AM. The description of the fall was as follows: Resident was being transferred from wheelchair to shower

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chair and the chair moved. The resident leaned forward and was put on the floor. Left knee area was possibly twisted. After the fall 2 CNA's (Certified Nurse Assistants) and nursing got R329 up to shower chair. Noted area 2 inches below left knee was swollen and complained of some pain. Doctor was called and an X-Ray was ordered and ice applied. The investigation into the fall on the event report also documents that the floor was wet in the shower room.

R329's Nurses notes document on 8/20/19 at 1:52 PM, X-Ray was here and they were waiting the results of the left knee scan. At 2:30 PM, X-Ray results were received that R329 had an acute mildly distracted fracture of the proximal left tibial diaphysis, superimposed upon a site of an old fracture. The physician was notified of these results and R329 was sent to the Emergency Room.

The quarterly MDS dated 7/8/19 documents R329's functional status as extensive assist, with two plus persons physical assist for transfer. Transfer is described on this form as how a resident moves between surfaces including to or from: bed, chair, wheelchair, standing position. The bathing was also coded as a 2 plus person extensive assist.

R329's fall risk assessment dated 7/8/19 (previous to the fall) had a score of 16. Per the assessment it considers a score of 10 or above represents a high risk for fall. Skilled nurses notes prior to the fall that occurred on 8/20/19 document daily that R329 was an extensive assist of two plus persons for transfers.

On 11/20/19 at 1:15 PM, V3 (Certified Nurse Assistant) stated that she was the staff member

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with R329 in the shower when he fell. V3 stated that she was alone with the resident transferring him that day. She went on to state that she usually uses a gait belt, and that morning R329 stated that he felt like he was strong enough that only one person needed to help him transfer.

On 11/20/19 at 2:00 PM, V2 (Director of Nursing) stated that they consider him a 1-2 person assist depending on now he is feeling for the day (strength wise), and that this is common; that they do this with most residents.

On 11/21/19 at 10:00 AM, V5 (Physical Therapist Assistant) clarified a therapy communication/in-service to nursing staff document dated 9/25/18 was the most recent document with therapy recommendations for transfer status, prior to R329's fall on 8/20/19. The current functional status of this document lists that the transfers for R329 were limited to 2 persons due to non-weight bearing status of the left lower extremity.

On 11/21/19 at 10:30 AM, R329 stated that he typically has 2 CNA's help transfer him since he cannot bear weight on that left leg. He was unable to bear weight on that leg prior to this fall, due to a previous injury to the same leg. R329 stated that he is not ever asked how he is feeling for the day to determine if he needs 1 or 2 CNA's to help with transfers. R329 went on to state that it is typically only when V3 is working that she tries to do it all herself, and that is what happened the day of the fall.

R329's current care plan has a focus area of cognitive deficit where it then lists that the resident has some confusion at times, poor decisions, and disorganized thoughts as side

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effects from a past stroke. Further review of care plan in its entirety and medical record does not document that R329 is to be asked prior to transfers/showering questions on strength to determine if 1-2 people are needed for assistance. During exit conference on 11/22/19 at 2:00 PM, V2 provided a previous undated care plan that documents prior to R329's fall he required an assist of 1-2 staff for transfers depending on how he was feeling. V2 went on to state that there is no formal way to measure how the resident is feeling, it is just determined by staff during morning ADL's (Activity of Daily Living). V2 was unable to determine when R329's previous status changed from a 2 person extensive assist to a 1-2 staff assist.

2. Physician's Orders for R59 dated 1/18/19 documents an order for, "Bolsters for bed when in bed r/t (related to) unaware of limitations."

R59's Plan of Care with a focus area of "Resident is at risk for falls r/t dementia, hx (history) of falls, unaware of limitations, psych med use." Interventions include, "Bed Bolsters x's 2" with an initiation date of 1/18/19.

The Accident Log Dated July 2019 documents on 7/15/19 at 1:00 AM R59 sustained a fall from bed with no injuries noted.

R59's "Event Report" dated 7/15/19 at 1 AM documents, "When this nurse came from West Wing to 300 hall the resident was noticed sitting on the floor beside her bed. Her front bolster (device used to protect an individual from falling out of bed), bed pad and covers were on the floor with her. She was sitting on a fall mat beside her bed." The root cause report of the incident states, "The back bolster was not fastened properly to

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S9999	Continued From page 5 the bed so when she moved the front bolster, bed pad, and covers slid off the bed- she had a fall mat beside her bed and was sitting on that. She did not hit her head." Interventions Implemented are listed as, "Bed re-made & bolsters applied properly." An additional note on this same document states, "Staff to be retrained on bolsters- main. (maintenance) has checked all bolsters in building to ensure attached correctly." An "In-service Education Program Attendance Sheet" dated 7/16/19 with a program title of "Proper Application of Bolsters" is documented as being complete. On 11/21/19 at 9:06 AM, V1 (Administrator) states R59's normal cognitive status is confused. V1 states R59 does not have the cognitive ability to remove her bed bolsters. V1 confirms the 7/15/19 fall investigation for R59 determined the bed bolster was not correctly applied to the bed, causing it to come off. V1 states the facility in-serviced staff on correctly applying the bolsters. (B)	S9999		