STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146172	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPRING CREEK	**777 DRAPER AVENUE JOLIET, IL 60432**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure fall interventions were in place for a resident at high risk for falls. This failure resulted in a resident falling from bed and sustaining a left hip dislocation. This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3. The findings include: R1's Face Sheet showed he has [DIAGNOSES REDACTED]. R1's January 4, 2020 Minimum Data Set showed R1 is severely cognitively impaired, requires extensive assistance of two people for transfers, and has a history of falls. R1's January 25, 2020 Fall Risk Review categorized R1 as a high fall risk and showed R1 had previous falls. The facility's March 11, 2020 Facility Incident Investigation Report showed On [DATE]20 at approximately (10:30 PM), resident was observed out of his bed on the floor positioned on his left side facing the door . On March 11, 2020 at 12:40 PM, R1 was on his back in bed. R1's left leg was rotated internally and it was shorter than his right leg. R1's March 11, 2020 X-ray result from 9:43 PM showed Dislocated total left hip replacement prosthesis. On March 12, 2020 at 9:45 AM, V12 CNA (Certified Nursing Assistant) stated she is always assigned to R1. V12 stated prior to his March 9 fall, R1 was always climbing out of bed .I don't know why . he's antsy. He has dementia. V12 stated if R1 is up in his chair and it is not reclined, R1 also attempts to get up. V12 stated R1 has always had fall mats, and always had alarms. V12 was asked how she knew which residents were fall risks, and she stated she refers to the Care Cards in the residents' closets. The undated Care Sheet in R1's closet showed he is at risk for falls, and uses a bed alarm, chair alarm, fall mat, and bed bolsters as fall interventions. On March 12, 2020 at 10:30 AM, V3 RN (Registered Nurse) stated fall mats are used in case a resident falls. V3 stated you do not want a resident to fall on the cement floor so mats can minimize risks of injury. V3 stated alarms are used for those residents who try to get up unassisted and the alarm reminds the resident and alerts the staff. V3 stated it is everyone's job to make sure that mats and alarms are in place. V3 added whenever a resident is in bed and they have mats, if you see they aren't there, they should be put down. On March 11, 2020 at 4:05 PM, V10 (RN) stated she was working with R1 on March 9, 2020 when he fell . V10 stated the CNA found R1 on the floor when she was doing her rounds. V10 stated when she saw him, R1 was lying on his left side on the door side of his bed. V10 stated R1's alarm was not sounding and it was not on him. V10 stated R1's fall mats were not in place and instead were leaning against the wall. On March 12, 2020 at 10:00 AM, V11 (RN) stated staff members have to follow protocol for fall interventions and have to ensure that the interventions are actually in place to prevent a fall. V11 stated if you know they've fallen you make sure they're in place. V11 stated alarms let us know someone is trying to get up and maybe we can get to them. V11 stated the purpose of the mats is to lessen injury. On March 12, 2020 at 12:35 PM, V6 (R1's Nurse Practitioner) stated R1's left hip dislocation was a result of his fall from bed on March 9, 2020. V6 stated she expects resident's fall interventions to be implemented. R1's Fall care plan focus (revised January 15, 2020) showed the intervention of bed alarm applied was initiated October 21, 2019. The facility's November 27, 2019 Fall Prevention Program policy showed The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions . The policy further showed 4.All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained .

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.