| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **145657** | A. BUILDING _____ B. WING _____ | **09/28/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **PROVIDENCE DOWNERS GROVE** | **3450 SARATOGA AVENUE DOWNERS GROVE, IL 60515** |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to provide fall prevention measures for one of four residents (R5) reviewed for falls in the sample of 4. The findings include: R5's electronic face sheet printed on 9/28/20 showed R5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R5's fall risk assessment dated [DATE] showed<br>R5 is a fall risk of 18 indicating she is at risk for falls and should have fall interventions implemented. R5's care plan dated 7/31/20 showed, (R5) is at risk for falls due to history of repeated falls, impaired mobility. Interventions include floor mats as indicated. Floor mattress on floor when in bed post fall 9/12/20. R5's physician orders [REDACTED]. On 9/28/20 at 1:05PM, R5's call light was on and her chair alarm was sounding. R5 was observed transferring herself from her wheelchair to her bed without staff assistance. V4 (Licensed Practical Nurse) walked by R5's room as her alarm was sounding and did not stop to assist her. V4 returned to R5's room, after dropping off a glass of water down the hallway. V4 then educated R5 on fall prevention and encouraged her to call for assistance instead of transferring herself. V4 then left the room with R5's wheelchair at bedside and floor mattress leaning against the wall opposite of R5's bed. On 9/28/20 at 1:40PM, V6 (Certified Nursing Assistant) was observed leaving R5's room. R5's wheelchair continued to stay at R5's bedside and her floor mattress leaning against the wall opposite of R5's bed. When asked, V6 stated, Oh I think we only put the mattress down at night. She doesn't need it all the time. She usually calls for help but doesn't always wait for us. I don't think she's had any falls. On 9/28/20 at 9:55AM, V4 (Licensed Practical Nurse) stated, Fall prevention measures are in place to prevent falls, if they are not in place then there is a higher risk of a resident falling and possibly getting injured. On 9/28/20 at 10:55AM, V5 (Certified Nursing Assistant) stated, If fall interventions are not in place, that could lead to a fall for a resident with possible injury. On 9/28/20 at 1:55PM, V2 (Director of Nursing) stated, Fall interventions are added to a residents care plan based upon their fall risk assessment. If a new fall happens, we review the fall and implement new interventions. If interventions are not in place, a resident could suffer another fall. A mattress next to the bed is most commonly used when a resident is in bed. If a resident is in bed I would expect the mattress to be on the floor next to the bed, not leaning up against the wall. That defeats the purpose of the mattress and provides no protection to the resident if a fall occurs. The facility's policy titled, Falls Reduction with a revision date of 06/08 showed, (The Facility) works in partnership with clients and families to maintain clients independence and enhance the quality of client lives by managing the risk for falls and fall related injuries .1. Identify client risks for fall. 2. Identifying and promoting fall reduction strategies. 3. Providing fall reduction education for staff, clients and families . |

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.