STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145460	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THRIVE LAKE COUNTY	**850 E US HIGHWAY 45 MUNDELEIN, IL 60060**

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 interview and record review the facility failed to ensure a resident at risk for falls, with recent falls, was adequately supervised and failed to ensure additional fall risk interventions were implemented to prevent further falls. This failure resulted in a resident (R2) continuing to have falls and receiving lacerations to the head requiring emergency room treatment and staples. This applies to 1 of 3 residents reviewed for safety supervision in the sample of 6. Findings include: R2's face sheet shows the admitted to the facility was 3/13/2016. R2's [DIAGNOSES REDACTED]. R2's 8/17/2020 facility assessment shows that she has a severe cognitive impairment, requires the use of a wheelchair, is not able to walk, and needs extensive assistance from staff for transfers, bed mobility, and toileting. On 8/24/2020 at 9:30 AM, V6 (Certified Nursing Assistant/CNA) said that R2 has had several recent falls. V6 said, We try to get residents who are fall risks up and not have them in their room. On 8/24/at 10:00 AM, V5 (Memory Care Director) said that R2 has had several recent falls and one resulted in staples to her head. When asked why R2 has not been moved closer to the nursing station, V5 replied that those rooms have males in them closer to the nursing station. On 8/24/2020 at 10:05 AM, R2 was observed in the hallway of the memory care unit outside of her room. R2's room is approximately 3/4 of the way down the hallway. It is not closest to the nursing station or day room area. There are 5 rooms in between. She is also the second bed in the room and is by the window, not the doorway. The hallway R2's room is on is not the main entrance to the unit and there would be less staff coming and going from the hallway where R2's room is located. R2's incident report investigation dated 5/22/2020 and completed by V1 (Administrator) shows that on 5/18/2020, R2 was found on the floor of her room. Upon nursing assessment, a laceration was noted to the top of her head. An order was received from her physician to send her to the emergency room . She returned to the facility with sutures in her head. R2's incident report dated 7/24/2020 at 4:40 PM, states that R2 was observed on the floor in her bathroom, noted [MEDICAL CONDITION] and moderate bleeding from head wound, cleansed, wrapped around and ambulance called. The same report shows that she also sustained a skin tear to her right elbow. R2's nursing progress fall incident progress note dated 7/25/2020 at 12:16 AM, states only [MEDICAL CONDITION], 7 staples on head. R2's final incident report investigation dated 7/31/2020 completed by V1 shows that R2 was observed on 7/24/2020 seated on the floor in the bathroom. She had a laceration to her head and was sent to a local ER for treatment. She returned with 7 staples to her head. R2's incident report completed by V3 (Registered Nurse/RN) and dated 7/27/2020 at 11:20 PM, shows that R2 had a laceration to her forehead that is about an inch long. R2's incident progress notes completed by V3 at 11:31 PM, states, According to CNA resident bumped head on the cart from the kitchen causing a laceration. On 8/24/2020 at 1:14 PM, V3 when asked by this surveyor about the incident on 7/27/2020 indicating that R2 ran into a kitchen cart, when asked how that would happen, V3 said, That's just what the CNA told me happened. V3 additionally said she is not sure what has been done for R2 to prevent falls. R2's incident report completed by V8 (RN) dated 8/11/2020 at 9:55 PM, states, Heard resident {R2} yelling for help found sitting on floor holding head bleeding right upper forehead once cleaned bleeding stopped and md called await response cleaned with sterile technique and steri strips applied. The same document shows that R2's physician (V9) gave an order to send her to the (ER). R2's fall incident progress note timed for 10:15 AM (an error in the entry) shows that she was sent to the ER at 11:00 PM. R2's nurses note dated 8/12/2020 4:10 AM, shows that she returned from the emergency room with an open area on her forehead. R2's incident report completed by V8 (RN) dated 8/13/2020 at 4:29 PM, states, Someone from the kitchen saw resident sitting on the floor in room alerted director who brought her to me. no bumps lumps or bruises or bleeding noted to head but small abrasion to right elbow was noted. R2's Orders-General Note from eRecord progress note completed by V8 and timed for 5:24 PM, states, This writer spoke with md informed we are getting ua cs but he wants further ways of maintaining safety he wants DON to call him. Information relayed to DON to call MD on 8-13. The same note shows that the resident was currently at the nursing station for 1:1. On 8/24/2020 at 12:57 PM, V8 said that when she spoke with V9 about R2's falls V9 told her something has to be done about R2 falling. V8 said that he indicated to her as stated above that he wants a call from the DON about all these falls and how to keep R2 safe. V8 said she relayed that message to V2. V8 said that all the staff have discussed their concerns about R2 falling and have given other suggestions such as a helmet and keeping her out of her room more. On 8/25/2020 at 10:20 AM, V9 stated, I am gravely concerned about all the falls R2 is having; these falls need to stop. Any one of these could be life threatening situations. V9 also said he has called and expressed his concerns with V2 and spoken with V5 about it as well. V9 said he gave an order for [REDACTED]. V9 said that he has indicated that more supervision is needed, maybe even a 1:1 staff, as well as some sort of protective device helmet. V9 also said to this surveyor Are you aware she had yet another fall last night and is in the emergency room again? Every time she falls and hits her head, she has to be sent out to rule out a brain bleed. R2 is a very fragile resident and I think she also needs some sort of helmet. R2's incident report dated 8/25/2020 at 12:27 AM, states, found resident in the hallway outside her room w blood on her forehead. Found 2 cuts measuring 1x1 and the other is 1x2. R2's nurses note dated 8/25/2020 at 9:39 AM, shows that R2 was transferred to a local ER by ambulance at 8:30 AM. The next nursing note on 8/25/2020 at 2:44 PM, shows that R2 returned from the ER at 12:30 PM with steri strips to her [MEDICAL CONDITION]. On 8/25/2020 at 2:10 PM, V10 (R2's Power of Attorney) said that she is very concerned with all the recent falls R2 is having. V10 also said the behavior with R2 scooting on the floor is not new; it has been happening for a long time. V10 said that the falls are getting worse, not better and the only additional thing they tell her they are doing is physical therapy and she does not know how that will help with the falls. V10 said, I got very little explanation on how R2 would have hit her head on a food cart in the dining area. In my head I am thinking if she has fallen this much there should be more interventions in place. V10 said when these falls happen, R2 is hitting her head each time. V10 said she had spoken with V9 earlier in the day and he told her he was concerned about the falls also. V10 stated, I keep waiting for the call that she has hit her head again and this is it. On 8/25/2020 at 11:00 AM, V1 confirmed that R2 fell again during the night and was currently in the ER. V1 said that R2 has the history of scooting herself on the floor. When asked why she had not been moved closer to the nursing station V1 said, As we discussed yesterday, due to the bed availability and isolation we could not move her sooner. When asked if they had increased staffing to help monitor R2, V1 stated, We feel the unit is appropriately staffed. On 8/25/2020 at 11:05 AM, V2 said that she had spoken with V9 about his concerns with R2 falling. V2 said, We cannot do 1:1's, or alarms because it is a restraint. We are encouraging 15-minute checks for R2 if doable. These checks are not documented anywhere in the medical record. V2 additionally said that R2 had fallen again last night. She was found on her floor scooting out of her room into the hallway. R2's care plan shows that she is at risk for falls. The care plan provided by the facility shows that the only recent intervention added was on 8/12/2020 and that intervention is to assist back to bed after meals. A care plan with a detailed intervention list showing dates all interventions were added was requested on 8/25/2020 via phone conference with

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.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) V1 and V2 and not received during this investigation. R2's current physician's orders [REDACTED].