STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145846	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE CENTER AT CENTER GROVE	**6277 CENTER GROVE ROAD EDWARDSVILLE, IL 62025**

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement person-centered interventions to address behavior problems for 1 of 8 residents (R12) reviewed for care plans in the sample of 26. Finding includes: On 9/10/20 V1, Administrator, provided three Incident/Accident Reports which involved physical aggression and sexually inappropriate behavior by R12 towards other residents in the facility. R12's Care Plan dated 2/5/20 documents he has both long and short term memory problems related to a [DIAGNOSES REDACTED]. R12's Incident Report, dated 2/28/20 documented R12 was kicking another's residents walker during an altercation in the dining room. There was investigation completed for this incident, and the only action by the facility documented on the report was that the two residents were separated. R12's Care Plan was not revised to address R12's new behavior of being aggressive towards other residents. R12's Incident Report, dated 8/10/20, documented at 11:30 AM, R12 pushed R17's wheel chair out of their shared room. The Report documented R12 threw a shoe at R17 and also struck R17 in the head with his hand. In the Summary of Investigator's Findings, the report documents A complete and thorough investigation was initiated to include chart review, interviews, observation, and assessments. R17 was unable to identify root cause of roommate conflict. His BIMS (Brief Interview for Mental Status) is 7 which indicated cognitive impairment. R12 was unable to communicate cause of conflict with roommate. His BIMS is generally a 13 and this is a change in status for him. This is an isolated incident for him as generally he is social and communicative and appears to stem from an organic issue. He has complained of not feeling well with new onset dizziness. MD (Medical Doctor) notified and labs were ordered. On 8/27/20 R12's Care Plan documented, (R12) has a perceived or actual mood problem and includes an intervention, Monitor/report any risk for harm to self or others. There was no person-centered interventions to address R12's behaviors. R12's Incident Report, dated 9/5/20 documented V16, Certified Nursing Assistant (CNA) reported to V1, Administrator, that while doing rounds at 3:00 PM on that date she observed R12 in a female resident's (R11's) room, in his wheel chair beside her bed and R12 had his hand around R11's peri area. The report documents the residents were immediately separated and placed on 1:1 supervision, and the police were notified. On 9/7/20 at 10:24 AM V18, CNA, stated she was instructed this morning when she came on shift that she was watching R12. She stated R12 has been mostly sleeping. V18 stated she has seen R12 talk aggressively to other residents and he has gone in other resident's rooms. She stated one day when she was working on R12's hall, he came out of his room with his shaver and went down the hall to a female's room R11, and she came out into the hall and he tried to shave her chin. V18 stated she and the nurse redirected R12 back to his own room. On 9/9/20 at 8:45 AM V5, Certified Nurse's Aide (CNA) stated R12 focuses on R11 a lot. She stated, I haven't seen him do anything but I hear things from other staff that he tries things, but don't know specifics. V5 stated, When I see him go in R11's room, I bring him back out; he cusses me out but that's ok. V5 stated he makes sexually inappropriate comments to female staff all the time. V5 stated she had to redirect him out of R11's room recently, and thinks R11 might like him because they both (R11 and R12) got mad at her when she made him get out, but V5 stated she knows R11 isn't 100 % and knows she doesn't always understand what's going on. On 9/9/20 at 8:55 AM V31, Registered Nurse (RN), stated she has been working as an RN for a couple of weeks, but worked at the facility as a CNA for the past 5 years and she is familiar with R12. V31 stated almost every day R12 would have to be redirected out of R11's room; he particularly liked to go in her room and talk to her and would try to talk her into coming to his room. V31 stated she reported these incidents to the nurses and the nurse would document it. V31 stated it was various nurses. V31 stated she was not aware of R12 talking inappropriately to R11 but everyone knew to keep an eye on her when he was around. V31 stated R11 has a bad memory and didn't realize it was not right. He would go in and call her sweetie or baby and try to help her get out of bed. On 9/9/20 at 9:20 AM V6/CNA/ Central Supply stated she had to frequently steer him (R12) away from R11's room. V6 stated it happened at least every other night, usually on evenings or nights. She stated she never witnessed any inappropriate touching, he just wanted to go into her room. V6 stated R11's response was that most of the time she didn't know what was going on. V6 stated on one occasion R11 stated for V6 not to put her bed down as R12 would be coming into her room. V6 stated R11 never yelled at R12 to get out. V6 stated she reported R12 going into R11's room to the nurse and stated the nurse on duty was usually V38, Licensed Practical Nurse (LPN). On 9/11/20 at 12:48 PM during a phone interview V38 stated staff are tracking R12's inappropriate sexual behaviors now, but she was not aware of R12 being sexually inappropriate toward staff before his incident with R11 on 9/5/20. V38 stated last night she asked his sitter if he had done anything or made any inappropriate remarks, and the sitter told her R12 had touched her thigh and told her she had good thighs, and she documented on his tracking. V38 stated before the incident on 9/5/20 she used to have to take him out of R11's room frequently, and have also caught R11 coming out of his room also. He would say that R11 was his girlfriend and she would say he was her boyfriend. V38 stated she would separate them and remind them about COVID and tell them they had to be 6 feet apart. She stated on the incident of them kissing in the hall that she documented on 7/30/20, I'm not for sure they were kissing, I didn't see the actual touching, but I heard the smacking sound, so I separated them and reminded them to stay six feet apart. V38 stated anytime she redirected R12 out of R11's room or told him to keep going if he stopped outside of R11's room, R12 was compliant and would listen to her. V38 stated sometimes R12 would get treats from his family and want to share them with R11, but V38 would not let him go in her room, but would take the treats to R11 for him. The facility did not develop a person-centered Care Plan to address R12 going into R11's room and his sexually inappropriate comments towards staff. The facility's policy, Comprehensive Assessments and Care Plans revised 10/18/19 documents: Standard: It will be the standard of this facility to make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment will include at least the following: (iii) Cognitive Patterns, (vi) Mood and behavior patterns, and (vii) psychological well-being. 7. The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. 10. The plan of care reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** A. Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent sexually inappropriate behavior towards a resident for two of two residents (R11 and R12) reviewed for supervision in the

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) sample of 26. This failure resulted in psychosocial harm for R11 in that R12 touched R11 in her peri area inappropriately and a reasonable person would react to such a situation with feelings of anxiety, distress, fearfulness and humiliation. Findings include: 1.R12's Face Sheet documents his [DIAGNOSES REDACTED]. R12's Care Plan dated 2/5/20 documents R12 has both long- and short-term memory problems related to a [DIAGNOSES REDACTED]. R12's Minimum Data Set ((MDS) dated [DATE] documented he is cognitively intact The Facility's Incident Report dated 9/5/20 documents V16, Certified Nursing Assistant (CNA) reported to V1, Administrator, that while doing rounds at 3:00 PM on that date she observed R12 in a female resident's (R11's) room. The Report documented V16 saw R12 in his wheelchair beside R11's bed and R12 had his hand around R11's peri area. The report documents R11 and R12 were immediately separated and placed on one-to-one supervision, and the police were notified. On R12's Care Plan, updated on 9/7/20 documents R12 had a behavior problem. The Care Plan goal documented (R12) will have fewer episodes of sexual behaviors by review date of 11/27/20. Intervention: Monitor (R12's) location and intervene as necessary to protect the rights and safety of others. Approach/Speak in a clam manner. Divert attention. Remove from situation and take to alternate location as needed. R12's Care Plan does not address R12's person-centered behavior including R12's history of physical aggression and going into female residents' rooms and how staff can prevent these occurrences. R12's Behavioral/Intervention Monthly Flow Records for June through August does not document the staff to track any type of sexually inappropriate behaviors. R12's Behavior/Intervention Monthly Flow Record for September 2020 documents the behaviors of withdrawal and inappropriate sexual behavior with no episodes of withdrawal documented for the month, and only one episode of sexually inappropriate behavior documented on 9/5/20. R11's Face Sheet documents her [DIAGNOSES REDACTED]. R11's MDS, dated [DATE], documents R11 is severely cognitively impaired and requires extensive assist with transfers, locomotion on and off unit, dressing, toileting, personal care and bathing. R11's Progress Note dated 7/30/20 at 6:30 PM documents, Resident noted to be kissing (R12) in hall. Informed not appropriate and have to be 6 feet apart. Residents separated. R11's Progress Note dated 9/5/20 at 4:00 PM documents, Call out to (V36, Medical Doctor), about incident on hall. Awaiting return call. R11's Hospital Report dated 9/5/20 documents, You were seen today for: Sexual abuse examination performed. No sign of sexual assault or trauma on pelvic exam and physical exam. R11's Progress Note dated 9/6/20 at 4:00 AM documents, Resident returned to facility via ambulance accompanied by 2 attendants per stretcher. R11's Care Plan dated 9/7/20 documents: (R11) has impaired cognitive function (confusion or memory problems) related to [MEDICAL CONDITIONS] and frontal lobe deficit. Interventions include: (R11) may show confusion or difficulty remembering things. Give simple instructions and break up tasks into smaller steps. Reorient her and give reminders as needed. Reassure her if she becomes anxious. Help her get to and participate in enjoyable and social activities. Report any new or worsening confusion to the nurse. On 9/9/20 at 2:20 PM V16, CNA, stated her shift on 9/5/20 started at 2:30 PM and per her usual routine she was doing her initial round on her halls to check on residents. V16 stated when she walked into R11's room at about 3:00 PM, R12 was in R11's room next to her bed in his wheelchair.V16 stated R11's covers, pants and diaper were pulled down and R12 was messing with her genitals, moving his hand in a fast motion and R11 was just staring at R12 wide eyed (could not say if she looked scared),but was not saying anything. V16 told R12 he had to get out of R11 's room and he said, OK, I was just saying goodbye to my girlfriend. V16 stated when she and the nurse (V17) went in later, R11 said R12 was bothering her. V16 stated she and the nurse asked R11 How?. V16 stated R11 responded R12 was playing with her privates. V16 stated they also questioned R12 what he was doing in R11's room and he stated he was playing with R11's breasts and bellybutton. V16 stated she knows R12 well and R12 talks inappropriately to staff, comments on their body, and when she would tell him not to talk to her that way, he would stop and go away. V16 stated R12 is independent and she mostly just had to check on him. She stated R12 would definitely know what was going on and was alert and oriented. V16 stated around 6:00 PM that same evening, another resident (R26) who lived across the hall from R11 told her (after the incident) that earlier that day, the male resident in a wheelchair with the hoarse voice ran his w/c into her door, opening it a little, then he went into that younger woman's room. V16 stated R26 told her she heard the man say, Give me a minute and I'll give you a baby. and I told you I'd get you one day. V16 stated she reported the conversation with R26 to V1, Administrator. V16 stated R26 is alert and oriented and knows where she is, has some long-term memory loss but short-term memory is good. V16 stated the man with the hoarse voice in the wheelchair would be an accurate description on R12. V16 stated R12 is a very inappropriate man. V16 stated after the incident occurred she and the nurse were in his room to assess him he stated, I don't know why you want to come in my room and look at my dick, but while you're down there, you may as well play with my balls. On 9/11/20 at 11:50 AM V17, Licensed Practical Nurse (LPN) stated she was filling in for the other nurse who was at lunch when the incident between R11 and R12 occurred. V17 stated after the two residents were separated, she went in and assessed R11 and asked R11 if there was a gentleman in the room earlier and what was he doing. V17 stated R11 stated, Yes, he was bothering me, and when asked how he was bothering her, she said, He was playing with my pussy. V17 stated R11 was not upset or frightened after the incident. V17 stated she went down to R12's room to assess him, and he stated that he was visiting R11 and they were talking, and when V17 asked if that was all they were doing, R12 stated he was touching her ti***** and belly button. V17 stated when she was doing a physical assessment on R12, he was sexually inappropriate to her, telling her she could come back the next day and look at his balls if she wanted to. V17 stated after she told R12 that was inappropriate, he stopped. She stated after the incident he always had a staff member with him. V17 stated she did not think R12 thought he did anything wrong to R11, because when she told him the behavior of touching R11 was inappropriate, R12 shrugged his shoulders and said, Well, if that's what you think. On 9/7/20 at 10:24 AM V18, CNA, stated she was instructed this morning when she came on shift that she was watching R12. V18 stated one day when she was working on R12's hall, he came out of his room with his shaver and went down the hall to a female's room (R11), and she came out into the hall and he tried to shave her chin. V18 stated she and the nurse redirected R12 back to his own room. On 9/9/20 at 8:45 AM V5, CNA, stated R12 focuses on R11 a lot. She stated, I haven't seen him do anything, but I hear things from other staff that he 'tries things', but don't know specifics. V5 stated, When I see him go in (R11's) room, I bring him back out. He cusses me out but that's ok. V5 stated he makes sexually inappropriate comments to female staff all the time. V5 stated she had to redirect him out of R11's room recently, and thinks R11 might like him because they both (R11 and R12) got mad at her when she made him get out, but V5 stated she knows R11 isn't 100 % and knows she doesn't always understand what's going on. On 9/9/20 at 8:55 AM V31, Registered Nurse (RN), stated she has been working as an RN for a couple of weeks, but worked at the facility as a CNA for the past 5 years and she is familiar with R12. V31 stated almost every day R12 would have to be redirected out of R11's room. V31 stated R12 particularly liked to go in her (R11's) room and talk to her and would try to talk her into coming to his room. V31 stated she reported these incidents to the nurses and the nurse would document it. V31 stated it was various nurses. V31 stated she was not aware of R12 talking inappropriately to R11, but everyone knew to keep an eye on her when he was around. V31 stated R11 has a bad memory and didn't realize it was not right. He would go in and call her sweetie or baby and try to help her get out of bed. On 9/9/20 at 9:05 AM V29, MDS/CPC (Care Plan Coordinator) stated R12 was not tracked for inappropriate sexual comments to staff or going in other resident's rooms because she did not know about it. V29 stated R12 has never said anything inappropriate to her. 9/9/20 at 9:10 AM V8, CNA stated, We had to watch (R12) when he was down on the 600-hall when we went in to do incontinent care for some of our female residents. He (R12) would follow us into the room stating he had to use the bathroom and he knew he couldn't be in there. 9/9/20 at 9:20 AM V6/CNA/ Central Supply stated she had to frequently steer him (R12) away from R11's room. V6 stated she stated it happened at least every other night, usually on evenings or nights. She stated she never witnessed any inappropriate touching, he just wanted to go into her room. V6 stated R11's response was that most of the time she didn't know what was going on, but she did make the comment once that she didn't want V6 to put her bed down because R12 would be coming into her room. V6 stated she reported R12 going into R11's room to the nurse before. She said she usually reported it to V38, Licensed Practical Nurse (LPN) was working. On 9/11/20 at 12:48 PM V38, LPN, stated staff are tracking R12's inappropriate sexual behaviors now, but she was not aware of R12 being sexually inappropriate toward staff before his incident with R11 on 9/5/20. V38 stated last night she asked his sitter if he had done anything or made any inappropriate remarks, and the sitter told her R12 had touched her thigh and told her she had good thighs, and she documented on his tracking. V38 stated before the incident on 9/5/20 she used to have to take him out of R11's room frequently and has also caught R11 coming out of his room also. He would say that R11 was his girlfriend and she would say he was her boyfriend. V38 stated she would separate them and remind them about COVID and tell them they had to be 6 feet apart. She stated on the incident of them kissing in the hall that she documented on 7/30/20, I'm not for sure they were kissing, I didn't see the actually touching, but I heard the smacking sound, so I separated them and reminded them to stay six feet apart. V38 stated anytime she redirected R12 out of R11's room or told him to keep going if he stopped outside of R11's room, R12 was compliant and would listen to her. V38 stated sometimes R12 would get treats from

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) his family and want to share them with R11, but V38 would not let him go in her room but would take the treats to R11 for him. V38 stated the inappropriate comments R12 made to the female staff before the incident on 9/5 were not tracked by her because staff never reported them to her. She stated she only found out about the comment he made to the sitter last night because she specifically asked her if he had done or said anything. On 9/9/20 at 2:10 PM, R11's daughter/ Health Care Power of Attorney, stated the facility made her aware of the incident between R11 and R12. V33 stated the facility sent R11 to the hospital and had her checked out and called the police. V33 stated R11 knew what was going on at the time but doesn't remember one minute later. She stated R11 would say she wondered if he liked it, then in the next minute she wondered if she was raped. V33 stated there was no trauma and R11 doesn't even remember it happened. V33 stated, when R11 was in her right mind, and alert and oriented, she would have told R12 no if he tried to touch her like that. V33 said the detective called her and said it was a unique situation. V33 said she knows the man was not in his right mind either. She stated she does not want it to happen to her mother again. A reasonable person would react to this inappropriate sexual behavior towards them with such feelings as agitation, anxiety, frustration, fearfulness and humiliation. B. Based on observation, interview and record review, the facility failed to investigate falls to determine the root cause of the falls, and initiate progressive interventions to prevent further falls, and failed to provide safe transfers techniques for 5 of 10 residents (R2, R3, R4, R6 and R14) reviewed for falls/accidents in the sample of 26. Findings include: 1.On 9/3/20 at 9:15 AM R2 stated she uses the slide board for transfers because of her right Above Knee Amputation (AKA). She stated she fell a couple weeks ago when she was bending over to pick something up and fell forward out of her chair. She stated she does not have a grabber. R2 stated no one has instructed her to do anything different since the fall or offered her a grabber so she doesn't have to bend over to pick up items if she drops them. On 9/3/20 at 10:10 AM V4, Certified Nursing Assistant (CNA) and V5, CNA, assisted R2 to sit up in bed, and R2 leaned over and fell to her right side once, and V4 assisted her to sit herself back up by placing her arm under R2 and lifting. V4 then placed a slide board under R2's left thigh and R2 slid herself from her bed to her wheelchair (w/c) with some hands-on assist from V4. R2 stated she gets very nervous when transferring because she is afraid of falling again. During the transfer, V4 and V5 did not put a gait belt on R2 for safety. R2's Face Sheet documents her [DIAGNOSES REDACTED]. R2's MDS dated [DATE] documents that she is cognitively intact and requires extensive assist with transfers. R2's Care Plan which was revised on 7/28/20 documents she is at risk for falls related to right [MEDICAL CONDITION] and [MEDICAL CONDITION] and requires assist with transfers using a slide board or full body mechanical lift, depending on how she feels each day. The interventions for her care plan include: Remind R2 to request assistance when getting up; R2 may need assistive equipment to help with transfers: 2 assist full body mechanical lift or slider board; Provide adaptive/safety equipment including but not limited to braces, splints, and mechanical lifts; Transfer: R2 is not able to help with transfer at all times and will need the assistance of 2 staff and a full mechanical lift to move from bed to chair and back. R2's Progress Noted dated 8/13/20 at 2:40 PM documents, On 1st day assessment post fall; patient alert and coherent. Denies pain related to yesterday's occurrence. R2's Fall Risk assessment dated [DATE] documents she is at risk for falls. There was no documentation in R2's medical record the facility conducted an investigation to determine a root cause of R2's fall on 8/12/20. R2's Care Plan was not revised after this fall with progressive person-centered interventions to prevent her from future falls. The facility's Accident and Injury Log, dated August 2020, does not document R2 having any falls in that month. On 9/10/20, at 10:05 AM, V1, Administrator, stated he could not find an investigation or an incident report regarding R2 falling on 8/12/20. 2. On 9/8/20 at 8:35 AM V8, CNA, assisted R14 from a lying position on her bed to a sitting position on the side of her bed. While doing this, V8 placed her hand under R14's arm pit, and pulled R14 up to a sitting position. R14 cried out in pain and stated she had fallen a few weeks ago and her hip was still sore. R14 stated she had gotten x-rays and they were ok but it still hurt some when she moved around. V8 assisted R14 to stand, putting her hand under R14's arm again and pulling her up. V8 then instructed R14 to pivot. V8 had pulled R14's wheelchair (w/c) too close to the bed and there was not enough room for R14 to move her legs and feet to pivot. V8 had to move the w/c further away from the bed and then R14 was able to pivot unsteadily. While V8 held onto R14's arm, R14 grabbed the arm rests on the w/c, and lower herself into the chair. V8 did not use a gait belt during the transfer. R14's Face Sheet documents her [DIAGNOSES REDACTED]. R14's Fall Risk assessment dated [DATE] documents she is at significant risk of falling. R14's Progress Noted dated 7/16/20 at 7:20 PM documents, Patient on floor due to fall, patient stated she pivoted from the bed to the chair and her gown got caught inside the wheelchair and caused her to fall. Patient in no distress or pain, performed a body assessment on patient, discovered patient had a lump on right thigh. The Note documented R14 was transferred to the local hospital for evaluation. R14's MDS dated [DATE] documents she is cognitively intact and requires extensive assist for transfers. R14's Care Plan, dated 5/13/20 and revised on 9/11/20 (after facility became aware that fall on 7/16/20 was not investigated), documents that R14 needs help transferring in and out of the bed or chair, and interventions include: one assist for all transfers; (R14) cannot transfer without help. R14 is able to stand but will need one or two people supporting her weight and helping them keep balance and upright for the transfer. Be prepared with two people to assist for safety. There were no progressive interventions after R14 fell on [DATE], and no mention of that fall in her care plan. The facility's Accident and Injury Log, dated July 2020, does not document R14 having any falls in that month. On 9/10/20 at 10:05 AM V1, Administrator, stated he could not find any incident reports or investigations of R14's falls in July or August 2020. 3. R3's Face Sheet documents R3 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] documents R3 is dependent upon staff for transfers and he is only able to stabilize his balance with staff assistance. The Care Plan dated 3/26/20 documents R3 requires an assist of one staff for ambulation, transfers and bed mobility. R3's Care Plan dated 4/17/20 documents R3 is at risk for falls with interventions to keep bed in lowest position, remind resident about safety awareness, and keep call light and personal items within reach and therapy evaluations as needed. The Fall Risk assessment dated [DATE] documents R3 is at significant risk for falls. R3's Nurse's Notes dated 5/4/20 at 1:03 AM documented R3 was observed on the floor by the roommate in his room. The Nurse's Note documented R3 sustained no injuries and denied complaints of pain. The Nurse's Note documented R3 was transferred back to bed with a mechanical lift by the nurse and three CNAs. The Note documented R3 was in and out of consciousness after being transferred to bed and was sent to the hospital R3's Hospital History and Physical (H&P) dated 5/4/20 document R3 was sent to the hospital after a fall and was admitted with the following Diagnosis: [REDACTED]. R3's Discharge Summary dated 5/6/20 documents R3 was discharged back to the facility on [DATE]. There was no documentation in R3's medical record regarding a fall investigation to determine the root cause of R3's fall. R3's Care Plan was not updated with progressive person-centered interventions to prevent R3 from future falls. On 9/10/20 at 11:50 AM, V1 stated the facility did not have an incident report or a fall investigation regarding R3's fall on 5/4/20. 4. R4's Face Sheet dated 9/7/20 documents R4 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. The MDS dated [DATE] documents R4 is cognitively intact, requires extensive assistance of one staff with transfers and is only able to stabilize himself with staff assistance when moving from a seated position to standing position, moving on and off the toilet and with surface-to-surface transfers. The Care Plan dated 4/8/20 with a revision date of 9/7/20, documents R4 is at risk for falls with interventions to keep the call light and personal items within reach, request assistance when getting up, non-slip footwear, reminders for safety awareness and therapy to evaluate and treat as needed. The Fall Risk assessment dated [DATE] documents R4 is at significant risk for falls. R4's Nurse's Notes document on 8/23/20 at 9 AM, R4 was being transferred with one assist, the CNA transferring resident stated as resident was pivoting he fell over on her. R4 had a skin tears to the left wrist measuring 1cm (centimeter) x (by) 1cm, forearm measuring 7cm x 1cm and elbow measuring 2cm x 1.5cm. No other injuries. Fall was witnessed. R4's physician and family were notified. R4's Care Plan was not revised after his fall on 8/23/20 with person-centered interventions to prevent R4 from future falls. On 9/10/20 at 11:10 AM, R4 states when he fell on [DATE], the CNA did not have a gait belt on during the transfer. On 9/10/20 at 11:10 AM, R5, R4's roommate, states the CNA did not have a gait belt on R4 during the transfer that resulted in R4's fall. On 9/10/20 at 11:50 AM, V1 stated the facility had no incident report or investigation regarding R4's fall on 8/23/20. 5. R6's Face Sheet dated 9/8/20 document R6 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. The Care Plan dated 4/9/20, with a revision date of 9/8/20 document R6 is at risk for falls with interventions to keep the bed in the lowest position, educate R6 about safety awareness and to request assistance when getting up. The Fall Risk assessment dated [DATE] documents R6 is not at significant risk for falls and is unable to understand or follow directions and is confused and disoriented. The Nurse's Notes dated 7/21/20 documents R6 had a witnessed fall at 7:30 AM. R6 had a knot on the left side of her head and a bruise on her left leg, the ambulance was called due to the knot on her head. The nurse's note dated 7/21/20 (no time) documents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145846	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE CENTER AT CENTER GROVE	**6277 CENTER GROVE ROAD EDWARDSVILLE, IL 62025**

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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) R6 returned from the hospital with no signs of pain or distress. R6's Care Plan was not revised after her fall on 7/21/20 with progressive interventions to prevent R6 from future falls. On 9/10/20 at 11:50 AM, V1 stated the facility had no incident report or investigation regarding R6's fall on 7/21/20. On 9/10/20 at 9:15 AM, V29, Care Plan Coordinator (CPC) states she updates the care plans with new interventions, the Interdisciplinary Team (IDT) determines the root cause of a fall and the staff have a book that they can go to that has information regarding a resident's transfer status. On 9/10/20 at 11:20 AM, V2, Director of Nurses (DON) states she would identify a root cause of a fall and document it on the fall sheet, the Care Plan Coordinator places a new intervention on the care plan with each fall. V2 states she would expect staff to use a gait belt and appropriate number of staff during a transfer. The facility's policy dated 6/1/06 and titled Gait Belt Usage documents A gait belt must be worn by the patient when you are transferring or ambulating the patient.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide complete incontinent care for 4 of 6 residents (R2, R6, R14, R18) reviewed for incontinent care in the sample of 26. Findings include: 1. R2's Minimum Data Set ((MDS) dated [DATE] documents she is cognitively intact and requires extensive assist with toileting, personal hygiene and bathing. The same MDS documents R2 is frequently incontinent of bowel and bladder. R2's Care Plan revised on 7/28/20 documents she is incontinent of urine and requires assist with incontinent care. R2's urinalysis laboratory report (UA C&S) dated 7/20/20 documents she had a urinary tract infection with greater than 100,000 E-Coli (bacteria). On 9/3/20 at 9:15 AM R2 stated the care has gotten better, but one night, after she had gotten injections in her eyes (8/17/20), V2 stated she was supposed to go to bed immediately upon returning to the facility. She stated she returned at 5:00 PM and was not assisted to bed until 10:45 PM. She stated she told the staff she was wet and dirty (wet when she arrived back to the facility, incontinent of bowel movement later) but there was only one CNA on her hall-stated they work short all the time. On 9/3/20 at 9:30 AM V4, Certified Nurse's Aide (CNA), performed incontinent care for R2, removing an adult diaper that was wet with urine, then using disposable wet wipes to cleanse left and right groin and vagina, without spreading R2's labia to cleanse her inner folds, or cleansing her inner thighs or lower abdomen of urine. 2. On 9/8/20 at 8:35 AM V8, CNA removed R14's adult diaper and R14 had been incontinent of bowel and bladder. V8 partially removed R14's diaper and cleansed the fecal material from around R14's rectum, but did not cleanse entire right or left buttock. V8 then rolled R14 onto back and cleansed her right and left groin and vagina, using same disposable wipe to re-wipe areas with disposable wipe that was already contaminated with urine. R14's MDS dated [DATE] documents she is cognitively intact, is dependent on staff for toileting and is incontinent of bowel and bladder. R14's Face Sheet documents a [DIAGNOSES REDACTED]. R14's Care Plan, revised 9/11/20 documents (R14) needs help with toileting, 1 assist for transfers. R14's Care Plan interventions include the resident will need the help of one or two staff to stand and transfer on and off commode or bed pan. The resident will probably need for you to wipe, redress, and wash their hands but allow the resident to do any part of the activity they can to promote independence. Be prepared with two people to assist for resident safety during the transfer. 2. The Face Sheet dated 9/8/20 documents R6 was admitted to the facility with a [DIAGNOSES REDACTED]. The Care Plan dated 4/9/20 with a revision date of 9/8/20 documents R6 being incontinent of urine with interventions to provide incontinent care as needed. On 9/9/20 at 9:45 AM, V8 and V20, CNA began to provide incontinent care for R6. R6 had two incontinence briefs on, the inner brief was wet with urine and R6 had a bowel movement. V20 wiped R6's anterior perineal area and the anal area. V20 failed to wipe R6's anterior thighs, posterior thighs or buttocks. 3. The Face Sheet dated 3/8/20 documents R18 was admitted to the facility with a [DIAGNOSES REDACTED]. The MDS dated [DATE] documents R18 is dependent upon staff for toileting and personal hygiene and is incontinent of bowel and bladder. The Care Plan dated 3/6/20 documents R18 has a self-care deficit and is dependent upon staff for toileting needs and to provide incontinent care as needed. On 9/9/20 at 8:30 AM, V26, CNA, provided incontinent care to R18. R18's incontinence brief was wet with urine. During the observation, V26 cleansed R18's anterior perineal area but did not cleanse the anterior thighs or any areas on the posterior side. On 9/10/20 at 11:20 AM, V2, Director of Nurses (DON) states she would expect to thoroughly cleanse the entire area front and back during incontinent care, to change gloves before cleansing a new area and wash their hands before and after providing incontinent care and use hand sanitizer between glove changes. The facility's policy, Standards and Guidelines: SG Perineal/Incontinence Care revised 9/1/17 documents: Standard: It will be the standard of this facility to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition and provide appropriate care and services required to maintain functional levels while providing perineal/incontinence care. Guidelines: 4. Provide perineal/incontinence care in accordance with the physician's orders [REDACTED]. 6. For a resident with urinary incontinence based on the resident's comprehensive assessment, the facility must ensure that-(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.