STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GROVE OF FOX VALLEY,THE	1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505

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 -** 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 that a monitoring alarm system was functioning in order to promote safe transfer to a resident who had a history of [REDACTED]. The findings include: The POS (Physician order [REDACTED]. R1's [DIAGNOSES REDACTED]. The nurse's notes, dated 2/25/2020, shows that R1 was admitted the facility on 2/25/2020 at 7:15 P.M. after being evaluated from the hospital due to a fall at home. The notes also showed that R1 was admitted with a hematoma on the left forehead, bruise on the back left thigh and a skin tear below left knee. The forehead hematoma was also with an open area. It was also documented that R1 was alert and oriented x 4 but forgetful. The notes also showed that R1 needed assistance to the bathroom with 1 person assist, gait was unsteady, and that R1 has poor safety awareness. The nurse practitioner (V3) notes, dated 2/27/2020, showed that R1 came from hospital due to a fall. R1 was admitted to the facility for skilled therapies. The neurological assessment showed that R1 was alert and oriented x 2. The plan included fall precautions. The care plan, initiated 2/26/2020, showed that R1 was a high risk for falls related to history of falls, weakness, multiple medical conditions/[DIAGNOSES REDACTED]. The goal was for R1 to be free of falls through next review due 5/26/2020. The interventions to prevent falls included the following: - Bed and chair alarm to alert staff and prevent falls. Staff to check alarm for placement and functions. -call light is within reach and encourage to use it for assistance as needed. R1 like staff to address needs with a prompt response to all request for assistance. The nurse's notes, dated 2/29/2020 at 11:00 PM, entered by V4 (Registered Nurse/Licensed Practical Nurse), showed was notified by (CNA, Certified Nurse Assistant) that (R1) was on the floor, (R1) was noted laying on her side in front of her bed. (R1) states (I fell while trying to go transfer from the recliner to my wheelchair to go to the bathroom. I hit my head on the wall.). Skin assessment done, pain assessment, vital signs, (R1) was transferred to her recliner chair with 2 person assist. Attending Physician notified, POA (Power of Attorney) notified. (R1) refused to go to the ER (emergency room) for evaluation and POA was okay with that. The incident report, dated 2/29/2020 at 8:00 PM, showed that R1 was on the floor lying next her bed and that R1 states she fell while trying to transfer from the reclining chair to wheelchair, and that R1 wanted to go to the bathroom. The report also showed that R1 stated she hit her head on the wall. The report also showed that there were no injuries, however, R1 refused to go to the hospital for further evaluation. On 3/5/2020 at 1:38 PM, V6 (Certified Nurse Assistant) stated that R1 was assigned under her care for 3-11 P.M. shift on 2/29/2020. V6 stated that she had closely monitored R1, and had taken R1 to the bathroom almost every 2 hours. V6 further added that before the fall, V6 took out the meal tray at 6:45 PM from R1's room. V6 also stated she had asked R1 if she needed assistance. V6 added that R1 was okay and did not need any assistance at that time. V6 also stated that at 7:45 PM, V6 went to R1 and assisted R1 to the bathroom. After the bathroom, R1 was assisted and sat down in her reclining chair. V6 stated that she did not check the chair alarm to see if it was connected and if it was turned on. V6 left R1 sitting in her reclining chair. On 3/5/2020 at 2:27 PM, V5 (CNA) stated that she was at the 500 wing nurse's station talking to a resident's family member around 8:00 PM on 2/29/2020. R1's room was 2 doors away from the 500 nursing station. V5 stated that the family member said, I heard someone asking for help. V5 immediately followed where voice asking for help was coming from. V5 added that it was R1 calling for help. V5 added that she found R1 on the floor, side lying position, and wheelchair was halfway on top of her. V5 also added she did not hear the monitor alarm going off. V5 added that R1 stated R1 hit her head on the wall but no bumps or blood was noted. V5 also stated that she immediately called for help, and V4 came in immediately, who was also on the same hallway passing medications to other residents. On 3/4/2020 at 4:42 PM, V4 stated that V5 called her immediately when R1 was on the floor on 2/29/2020 at 8:00 PM. V4 added that she was passing medications to other residents on the hallway of the 500 unit. V4 added that she did not hear R1's chair monitoring alarm going off. V4 added that there were no injuries sustained from the fall. V4 also added that she and R1's visitor that happened to come during the fall incident, found the chair alarm cord was not connected to the monitor unit box. V4 also added that the cord should be connected to the box of the monitor system to ensure it would sound off when R1 would attempt self-transfer. V4 also added that R1 refused to go to the hospital for evaluation, and close monitoring including neurological assessment was implemented post fall. V4 also stated that prior to the fall, R1 had been having loose stools and was frequently being assisted to the bathroom. V4 also stated that R1 was alert and oriented x3, with bouts of forgetfulness, poor safety awareness, and was impulsive when she wanted to get up and go to the bathroom. During the survey, random observation was made. R1 was seen sitting in her reclining chair. R1 was alert, responding to questions when asked. R1 stated she kept falling from the other place, and that she fell at the nursing home few days ago. I tried to go to the bathroom, called for help, guess they did not hear me and I really need to go. I cannot have stool in my diaper. So I decided to get up and not wait for them. I don't know how long I waited, but I cannot wait, so I ended up on the floor. They came at once when I was on the floor. I yelled for help. R1 was noted to be calm when talking with soft, low toned of voice.

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.