STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145494	A. BUILDING _____ B. WING _____	09/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MCLEAN COUNTY NURSING HOME	901 NORTH MAIN NORMAL, IL 61761

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on interview and record review the facility failed to implement it's abuse reporting policy by failing to provide written notification of abuse allegations to resident representatives for two of three residents (R4 and R5) reviewed for abuse on the sample list of 12. Findings include: The facility's policy, with a revision date of July 2020, titled Abuse Prohibition documents, FACILITY POLICY: McLean County Nursing Home affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. REPORTING REQUIREMENTS AND INVESTIGATION: This facility's identified Abuse Prevention Coordinator is the ADMINISTRATOR. b) A facility administrator who becomes aware of alleged abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. 1. R4's allegation of abuse investigation file dated 4/30/2020 documents on 4/30/2020, R4 stated that four staff members came into her room last night and stated they were going to have a party. One staff member was going to show the others how to put R4 to bed. R4 stated that the staff member had never put R4 to bed before so how could she show them how to put her to bed. Resident stated the staff member rammed R4's hand into R4's walker and caused a bruise to R4's left hand. Resident stated the staff were rough. 2. R5's allegation of abuse investigation file dated 1/13/2020 documents, on 1/13/2020 the facility received a call from the wound clinic where R5 is regularly seen. Nurse from clinic reports that R5 was stating that R5 was abused by a staff member of the facility. R5 states that on the Sunday before thanksgiving R5 was mistreated and abused by V4 C.N.A (Certified Nursing Assistant). R5 stated that V4 was mean refused to take R5 back to R5's room, called R5 a liar, told R5 that R5 did not belong here, and left R5 on the toilet until R5 started having a panic attack. R5 stated that R5 thinks V4 is on drugs. R4 and R5's medical record and abuse investigation files did not contain documentation that written notification was provided to resident representatives when allegations occurred per facility abuse policy. On 8/27/2020 at 2:45 PM V1 Administrator stated when an allegation of abuse occurs the nursing staff notify's the family by phone and documents in the nurses notes. At 3:50 PM, V1 Administrator stated I do not see in R4 and R5's abuse investigation files or medical records that R4 and R5's family members (resident representatives) were notified in writing of the abuse allegations per facility policy.
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 record review and interview the facility failed to develop and implement interventions to prevent an injury for one of three residents (R1) reviewed for falls with injuries and failed to complete quarterly and as needed fall assessments for two of three residents (R1, R2) reviewed for falls in the sample list of 12. This failure resulted in R1 rising from R1's wheelchair unassisted and falling to the floor which resulted in a left [MEDICAL CONDITION] requiring surgical repair. Findings include: The facility's Fall Prevention policy with a revised date of 2/28/19 documents, A fall will be defined as unintentionally coming to rest on the ground, floor or other lower level, not intentionally from an overwhelming external force or other purposeful action. Residents will be assessed for their fall risk: The facility nurse will be responsible for completing the Fall Risk Assessment on admission. The MDS (Minimum Data Set) Coordinator or designee will update following any significant change of status and as needed. On regular intervals which includes quarterly/annually MDS 3.0 Assessments. At any time necessary as assessed by the nursing administration. The Nurse Managers are responsible for: completing the fall-risk assessment at the appropriate intervals, Updating resident care plans appropriately and to ensure proper interventions are in place. Nursing staff including RNs (Registered Nurses), LPNs (Licensed Practical Nurses), and CNAs (Certified Nursing Assistants) are responsible for: Helping Nursing Administration with input to complete fall risk assessments upon admission and following a fall or change in condition of a low risk resident. To ensure procedures for high risk fall patients are in use. 1.) R1's Face Sheet dated 7/21/20 documents [DIAGNOSES REDACTED]. R1's Minimum Data Set ((MDS) dated [DATE] documents R1 has moderately impaired cognition. This MDS documents R1 required limited assistance of one person for transfers and for walking. R1 required extensive assistance of one person for toileting. This MDS documents R1 was not steady moving from a seating to a standing position and required staff assistance to stabilize self. This MDS also documented R1's Range of Motion was impaired on both lower extremities. R1's medical record documents fall events on 3/22/20, 5/22/20 and 7/17/20. R1's medical record documents an annual Fall Risk assessment dated [DATE] which documents a moderate fall risk. The next fall risk assessment in R1's medical records is a Quarterly assessment dated [DATE], almost six months later, and documents R1 is a high risk for falls with altered awareness of immediate physical environment. R1's medical record does not document fall risk assessments following the 3/22/20 fall or the 5/22/20 fall and R1's medical record does not document a quarterly fall risk assessment between the 12/19/19 assessment and the 6/11/20 assessment. R1's Restorative Note dated 3/5/20 completed by V26 Registered Nurse (RN), documents R1 requires one person assist for a stand pivot transfer. R1's Restorative Note dated 6/9/20 completed by V27 RN documents the same requirement for R1 to have one person assistance for a stand pivot transfer. R1's Care Plan with a start date of 12/25/17 and updated 7/23/20 documents R1 is at risk for falls with interventions dated 5/28/20 to keep gait belt in reach, 3/23/20 to remind resident to use the call light for assistance when wanting to get up, 5/3/18 resident reoriented and re-educated to use call light and encourage to use it, 12/25/17 fall risk assessments quarterly and prn (as needed). On 8/31/20 at 2:43 PM, V2 confirmed that there were no quarterly fall assessments completed nor were there fall assessments completed with the falls for R1. On 8/31/20 at 4:00 PM, V2 Director of Nursing provided a portion of R1's Care Plan that was not available in the electronic record which documents a problem date of 3/8/20 and documents R1 has the inability to ambulate independently due to unsteady gait and general weakness. R1's Nurses Progress notes dated 7/17/20 at 7:51 PM, by V13, RN documents staff heard resident yelling Hey, hey and as they started walking towards the yelling, the resident was yelling help, help, I've fallen. Staff ran to find resident (R1) laying on R1's left side next to R1's wheelchair, R1 stated that R1 was standing up, lost R1's balance and fell . Upon attempting assessment R1 verbalized severe pain to the left hip and lower back. Left lower extremity was noted to be abnormally rotated outward. R1 was unable to wiggle toes or move. R1 stated that R1's back hurt. Staff was instructed to not move resident and writer (V13) called 911. Ambulance arrived and R1 was taken to the hospital. SBAR (Situation, Background, Assessment and Recommendation) and bed hold were faxed to the hospital and POA (Power of Attorney) and PCP (Primary Care Physician) were notified. R1's Fall Investigation dated 7/17/20 documents R1 was last seen at 6:45 PM, however none of the witness statements document visualizing R1 at 6:45 PM. V28 Certified Nursing Assistant's (CNA) witness statement documents that V28 saw R1 last at 5:00

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) PM when V28 took R1 to the toilet before supper. On 9/1/120 at 8:34 AM, V28 confirmed that was the last time V28 saw R1 before R1 had fallen. V29's witness statement documents that V29 did not start V29's shift until after R1 had already fallen. On 9/1/20 at 9:00 AM, V13 Registered Nurse (RN) stated V13 was the one that saw R1 at 6:45 PM on 7/17/20. V13 stated R1 was in R1's room in R1's wheelchair at the end of R1's roommates bed reading a newspaper at 6:45 PM. V13 stated a little after 7:00 PM V13 heard a resident yelling for help so V13 went running and found R1 on the floor in R1's room. V13 stated R1 was non complaint with waiting for assistance to stand and transfer. V13 stated often times they would find R1 already on the toilet in the bathroom because R1 had taken R1's self to the toilet or they would find R1 in the doorway of R1's room with the depends at R1's knees because R1 took R1's self to the bathroom but could not pull up the depends afterwards. R1's hospital emergency room History and Physical dated 7/17/20 documents the chief complaint as fall from bed at nursing home. Hospital's assessment and plan document, R1 was unable to move R1's leg. Hospital Assessment/Plan documents a [AGE] year old female with known history of Dementia was sent to the hospital with noted unwitnessed fall, patient (R1) has been unable to move (R1's) left leg and is unable to give any history. Upon presentation to ED (Emergency Department) noted to a have left [MEDICAL CONDITION]. Will admit for possible operation tomorrow morning. R1's Radiology Report dated 7/17/20 at 9:03 PM, documents acute comminuted and displaced intertrochanter femoral fracture. R1's Surgical Case Record dated 7/18/20 documents actual procedure as left long intramedullary nail. R1's Nurses Progress Note dated 7/21/20 at 5:17 PM, documents R1 returned to the facility by ambulance. R1 was slightly confused. R1 had two incisions on left hip from the hospital stay. There were 16 staples in the top incision and six staples in the bottom incision. On 7/21/20 at 6:49 PM, R1's Nurse's note documents R1 was unable to take R1's medications whole as R1 did previously. This Nurse's note documents the medication had to be crushed and administered to R1. On 8/31/20 at 2:43 PM, V2 confirmed that the facility was aware that R1 frequently stood up without assistance and there is not anything documented prior to the 7/17/20 fall that the facility was doing to prevent the fall with injury. V2 stated that they could have done 15 minute checks, rounding every hour or kept R1 in a more supervised area. On 9/1/20 at 8:34 AM, V28 Certified Nursing Assistant (CNA) confirmed V28 last saw R1 at 5:00 PM on 7/17/20 when V28 took R1 to the toilet and V28 left the facility at 6:00 PM. V28 also stated that R1 stood up a lot without assistance. 2.) R2's face sheet printed 9/1/20 documents [DIAGNOSES REDACTED]. R2's medical record documents R2 had falls on 8/01/2020 at 4:25 PM, 7/30/20 at 2:27 AM, 7/26/2020 at 9:44 AM, 7/23/2020 at 12:44 AM, 7/22/2020 at 9:13 PM, 6/26/2020 at 8:21 PM, 6/18/2020 at 4:30 PM, and 5/03/2020 at 11:29 PM. R2's Care Plan dated 3/03/2020 documents R2 is at risk for falls related to Confusion, Forgetfulness, Poor Sleeping Habits, Lack of Personal Safety Awareness, Intermittent Impaired Balance and the use of medication known to increase the risk of falling. This Care Plan documents interventions for falls as placing safety mats next to the bed, medication review, make sure R2 has warm clothing on and Fall Assessments to be completed quarterly and prn (as needed), R2's Transfer assessment dated [DATE] documents R2 transfers independently. R2's Fall Risk assessment dated [DATE] documents R2 transfers independently. R1's next fall assessment is dated 6/4/20 which documents R2 is now a high risk for falls. R2's medical record does not document fall risk assessments being completed with each fall. R2's medical record documents the quarterly fall assessment completed on 6/4/20 was due in May, 2020. On 8/31/20 at 2:43 PM, V2 confirmed that fall assessments were not completed with the falls for R2 and quarterly assessments were not completed on time. V2 stated that R2 had a significant decline from March to June when R2's family could no longer visit on a daily basis due to COVID-19 like they had previously.