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F 000	INITIAL COMMENTS Facility Reported Incident of 4/6/21/IL132870	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement interventions to prevent falls and failed to complete a thorough post fall investigation. These failures affect three of three residents (R1, R2, R3) reviewed for falls in the sample of three. These failures caused R1's fall resulting in R1's sternum fracture, severely comminuted fractures of the jaw, and concussion. These failures also caused R2's fall resulting in a nondisplaced hip fracture. Findings include: 1.) R1's Progress Notes dated 3/2/21 at 11:16pm document R1 admitted to the facility at 6:10pm with diagnosis of Urinary Tract Infection (UTI) and Age Related Debility. R1's Physical Therapy (PT) Discharge Summary dated 3/15/21 documents R1 was discharged from Physical Therapy (PT) on 3/15/21. This summary documents R1 requires Stand By Assist	F 689	F 689 (SS=G) Alleged deficiency: Based on observation, interview and record review, the facility allegedly failed to implement interventions to prevent falls and failed to complete a thorough post fall investigation. 1. What actions have been taken to address and correct the deficiency? Care plans and fall investigation reports for R1, R2, and R3 were instantly reviewed by the MDS coordinator and nursing staff upon exit of surveyor. Where appropriate, said plans of care were immediately updated to reflect all appropriate interventions based on fall history, incident report, physician's orders, and where applicable, therapy notes. Additionally, plans of care were then also reviewed by the DON, ADON, and Administrator. While R3 has since made wonderful progress with the ability to	5/18/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/11/2021

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F 689	Continued From page 1 (SBA) for all functional mobility due to decreased awareness of limitations. R1 has limited potential for further gains and R1 "will not likely reach" independent levels. R1's Care Plans dated 4/19/21 document R1 is at risk for falls with a goal of no serious injury. These Care Plans document R1's fall prevention interventions including assist R1 with activities of daily living. These Care Plans document R1 needs limited assist for transfers and supervision with toileting and personal hygiene. R1's Minimum Data Set (MDS) dated 4/6/21 documents R1 requires supervision with transfers, toileting, personal hygiene and walking in R1's room. R1's Progress Notes dated 4/6/21 document R1 fell while opening R1's bathroom door and hit R1's face. This note documents R1 had a medium laceration below R1's chin and had a lot of generalized pain. R1 was transferred to a wheel chair and "complained of intense sternal pain." R1 was transferred to the emergency room. On 4/7/21 at 4:28am, the hospital notified the facility R1 was being transferred to a hospital out of town with a diagnosis of a fractured sternum and fractured jaw. The facility's fall investigation file for R1's fall on 4/6/21 at 10:00pm documents the following: R1's Resident Fall Report documents R1 was ambulating independently in R1's room. The facility failed to document R1's temperature and pulse post fall documenting "forgot but were WNL (within normal limits)." This report documents R1 sustained a laceration to the chin and an abrasion	F 689	advance back to her Independent Living apartment (move took place on 05/05/2021), appropriate interventions were up to date prior to her departure and as of as of today (05/10/2021) are also up to date for R1 and R2. R1 and R2's Kardex also reflect appropriate needs. All pressure pads were replaced with new and marked appropriately with warranty expiration dates. An in-service was also immediately scheduled for nursing staff in a valiant effort to re-educate team on post fall investigations and updates to the plans of care when incidents occur. Said in-services are scheduled for 05/13/2021 at 4 different times in order to catch all nursing team members. 2. How will the facility assure no other examples of the deficiency exist? An initial audit has been initiated on all residents with falls over the past 30 days to determine if the post-fall assessment was thoroughly completed and if new interventions were appropriately applied/ordered. Any identified concerns will be addressed accordingly and immediately. This audit includes Plans of Care & Kardex review for all residents at high risk for falls. 3. What measures will be put in place or changed to ensure deficient problems will not recur? The Director of Nursing and Assistant Director of Nursing will complete routine inspections daily of any fall investigation	

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F 689	Continued From page 2 to the right knee. R1 was transferred to the emergency room for "sternal pain" and laceration. This report also documents "(R1) is independent. When cleaning up for the night, (R1) went to close (R1's) bathroom door. (R1) fell for some reason and fell on (R1's) face." R1 knocked on the bathroom door until someone found R1. This report documents the root cause of R1's fall was that R1 "lost balance when closing a door" but does not document an investigation in to why R1 lost R1's balance or why R1 was left alone while up in the bathroom. R1's The Story of My Fall sheet dated 4/6/21 at 10:00pm documents V4, Certified Nursing Assistant (CNA) "encouraged (R1) to do (R1's) cares." This sheet documents "What fall interventions were in place? (R1) was independent." This sheet is blank for the question if fall interventions were in place/applied appropriately. This sheet documents what time R1 was last toileted with the answer "independent." The facility's final report to the State Survey Agency dated 4/12/21 documents "staff" were doing rounds and heard a faint knocking on R1's door to the hall and found R1 on the floor by R1's bathroom. R1 was sent to the hospital for complaints of "pain upon movement in sternal area" and then transferred to a hospital out of town and admitted with diagnoses of Bilateral Mandibular Condyle Fractures and Sternal Fracture. R1's Hospital Trauma Evaluation History and Physical (H&P) dated 4/7/21 documents "Trauma Level 2" and R1 was involved in a ground level fall at the facility. "It was unclear how long (R1)	F 689	reports to ensure proper documentation is completed not only on the care plan, but on the incident report itself. A pressure alarm check (to include warranty expiration dates) will also be utilized when initiated for a resident. Therapy will also be alerted and be required to assess appropriate residents after each fall to determine whether therapy services may be an option. Checks and balances between care plans, the fall investigation report, and any applicable therapy notes will be evaluated to safeguard that all are in concert with the plan of care. The Resident Fall Report and Post Fall Assessment (which will replace the "Story of My Fall") have been revamped to include more specific information as it pertains to what potentially led up to the incident. Please see attached appendices marked "A" & "B". On said report, the staff will collect and evaluate information until either the cause of the falling is identified, or it is determined the cause cannot be found or finding a cause would not change the outcome or management of falling and fall risk. Based on the assessment the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. In addition, a Pressure Pad/bed or chair/ Pull tab /15-minute checks/ Wander guard checklist has been created. Please see attached appendices marked "C" and "D". These new checklists will be distributed to nurses to complete upon initiation or discontinuation of above-mentioned items and once complete, will require a	

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F 689	Continued From page 3 was down before (R1) was found." R1 fell forward hitting R1's chin and chest. "(R1) is currently complaining of severe chest pain, mandible pain making it difficult to talk." This H&P documents R1 is assessed and having difficulty taking "big breaths" due to pain. R1 is having bilateral mandibular tenderness with mild swelling and chin laceration. R1 is also having difficulty opening R1's mouth fully due to pain. R1's chest had area of redness, mild swelling and "severe tenderness" over the right upper chest. R1's Computed Tomography (CT scan) dated 4/7/21 of the facial bones and mandible documents R1 with moderate to severe head trauma after a fall at the facility. This result documents R1 "demonstrates a severely comminuted intra-articular fractures of the mandibular condyle bilaterally extending in to the mandibular rami. The fracture appears to be displaced on the right side with dislocation at the right temporomandibular joint." R1's CT scan results of the chest dated 4/7/21 documents "Rib fracture suspected, traumatic." R1 presents to the emergency department after having a ground level fall. These results document R1 has a nondisplaced lower sternal fracture with a small amount of retrosternal hematoma. R1's Physician Note dated 4/8/21 documents R1's diagnoses including "fall from ground level resulting in sternal and bilateral mandibular fractures." R1's After Visit Summary dated 4/8/21 documents R1 had a "concussion (hit head on a counter during a GLF (ground level fall) that fractured	F 689	"sign-off" by DON or ADON to ensure all orders, interventions, and procedures are complete and documented appropriately in chart and plan of care. Where applicable, pressure pad initiation for a resident will be added to the TAR (Treatment Administration Record) to reflect warranty initiation and expiration dates as well as routine rounding by nursing staff to ensure alarm is working properly. Pressure pad application to be added to TAR (Treatment Administration Record) to reflect warranty initiation and expiration dates. Nursing staff will be in-serviced on 05/13/2021 regarding the new checklists and reports, the Kardex System, as well provided a refresher for plans of care interventions needing to be added or subtracted. This in-service will also include the re-education of policies and procedures as they relate to interventions to prevent falls. This re-education and review of processes will ensure nursing staff are adhering to the appropriate procedures as the facility makes every effort to prevent such incidents. 4. How will the facility monitor corrective action? As a measure of ongoing compliance, the Director of Nursing or designee will audit compliance of safety interventions upon each receipt of Resident Fall reports to ensure compliance with resident safety interventions. Findings will be trended and reported to the QAPI committee until substantial compliance is attained. The Assistant Director of Nursing will monitor	

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F 689	Continued From page 4 (R1's) mandible and sternum.)" R1 "will need close supervision..." This summary documents recommendations from V6, R1's Oral Surgeon for R1 to be served a pureed diet for comfort for 4-6 weeks with advancement to soft chew as tolerated due to R1's mandible fractures. R1's Progress Notes dated 4/19/21 at 5:40am document R1 was found on the floor in front on the bathroom with R1's walker at R1's side. R1 stated that R1 lost R1's footing and fell backwards on R1's buttocks and hit R1's head. R1's head was noted to have a slightly raised reddened area to back of the head. On 4/21/21 at 10:42am R1's talking was limited and hard to understand as R1 was unable to fully open/move mouth due to jaw fractures and dislocation as well as pain from those injuries. At this time R1 reports R1 was taking short breaths because of sternum pain when R1 breathes. R1 stated R1 broke R1's "chest bone (sternum)" while using hand to point to sternum and R1's jaw. When R1 was asked about R1's pain related to the fractures, R1 stated, "oh, I definitely have pain" and reported ear pain due to R1's jaw injury. R1's right side of temple/face area has significant amount of blue/green bruising. R1 was able to recall R1 fell causing the fractures of the jaw and sternum, but unable to provide a cause of the fall. R1 also stated R1 had another fall but was unsure of the date/time of the second fall. R1 stated, "I hope I didn't break any bones that time." On 4/21/21 at 3:49pm, V3, Assistant Director of Nursing (ADON) stated V1, Director of Nursing (DON) and V3 review the fall reports together and V3 enters the information in to the facility fall management electronic record. V3 stated R1	F 689	and maintain the QA logs monthly. The Director of Nursing/Assistant Director of Nursing will report findings at the quarterly QA meeting and additionally review with Medical Director and Administrator during weekly meetings in an effort to also identify individuals with a history of falls and risk factors for subsequent falls. Completion Date: 05/17/2021 See appendices marked "A", "B", "C", and "D"	

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"was independent when (R1) fell." When asked about how V3 was aware R1 was "independent" V3 stated "might have been passed on." V3 stated the certified nursing assistant (CNA) completes the document titled "The Story of My Fall" and the nurse completes the other handwritten assessments/investigation paperwork. V3 confirmed the handwritten documents from the staff document R1 was independent although R1's Care Plans and Physical Therapy notes document R1 required assistance. V3 stated therapy notifies nursing of resident's needing assistance with activities of daily living (ADL) and that the staff should be reviewing each resident's Care Plans to see the level of assist the resident requires. V3 stated V3 had not received the investigation documents related to R1's fall on 4/19/21 as of 4/21/21. V3 stated during review of what the staff submit regarding falls, V3 and V1 try to find a "reasonable intervention" if needed instead of or in addition to the intervention the nurse who completed the fall investigation implemented.

On 4/22/21 at 3:40pm, V4, Certified Nursing Assistant (CNA) stated R1 was in R1's bed when V4 told R1 it was time for bed time cares and placed R1's items in R1's bathroom and left the room. V4 stated V4 "left everything on the sink for (R1) to do it." I left the room and came back and R1 had gotten up and in to the bathroom and started to complete bedtime cares. V4 stated V4 left R1 standing alone in the bathroom and went to let the nurse know R1 was doing night time cares and the nurse "was like okay." V4 stated R1 went in to the bathroom to complete cares independently and V4 was not with R1 while R1 ambulated to the bathroom. V4 stated V4 had come back to R1's room and "peeked in" on R1

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who was still brushing R1's teeth. V4 stated another resident, R4, had requested to be assisted to the bathroom so V4 left R1 alone in R1's bathroom to assist R4 in another room. V4 stated when V4 came out of R4's room, there were more call lights so V4 went and answered other call lights as call lights kept going off. "A little while later (V4) heard a knock on a door and I had to figure out where it was coming from. V4 stated V4 finally figured out the knock sound was coming from R1's room. V4 stated V4 opened R1's door to R1's room and that is when V4 found R1 on the floor. V4 stated V4 didn't "know how long it had been" since V4 had checked on R1 nor how long R1 was on the floor. V4 stated staff review resident's Care Plans to find what level of assist the resident's require. V4 stated V4 knew R1 needed assistance with hygiene, but was never told R1 could not walk by self or that R1 was not independent."

2.) R2's Physical Therapy Evaluation and Plan of Care dated 3/5/21 documents R2's diagnoses including Fracture of Thoracic Vertebra, Syncope and Collapse, Difficulty walking Unsteadiness on Feet and History of falling. This evaluation documents R2 has a history of falls and feels unsteady when standing and walking. This evaluation documents R2's right and left lower extremity strength as "impaired" and R2's current mobility assessment for walking 10 feet, 50 feet and 150 feet as requiring supervision or touching assistance.

R2's fall investigation documents R2 had a fall on 3/8/21 at 11:50am and documents the following:

R2's Resident Fall Report documents prior to the fall on 3/8/21 at 11:50am, R2 was ambulating

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independently in R2's room. This report documents R2 was found on the floor sitting against the wall. R2 "was upset" after being told R2 could not return to R2's apartment, went to the bathroom and lost R2's balance when walking out of the bathroom and fell. This report documents R2 stated R2 hit head off of wall "a little bit." The root cause documents loss of balance due to R2 was worked up after being told R2 couldn't go back to R2's apartment. The area Fall Risk Category does not document what fall risk category was identified for R2. There is no documentation R2 was safe to be independent in R2's room. This report documents R2 complained of left shoulder, left leg and groin pain and had redness to the left arm by R2's shoulder and was sent to the emergency room for evaluation.

R2's The Story of My Fall dated 3/8/21 at 11:50 documents R2 stated R2 "forgot to use" R2's walker when coming out of the bathroom. R2 stated there were no staff present when R2 fell and R2 was not wearing R2's glasses when R2 fell. This report documents fall interventions that were in place including R2 was using walker, but does not document R2 had supervision or assistance of staff while R2 was ambulating.

R2's Computed Tomography (CT) scan of the left hip results dated 3/8/21 documents R2 was found to have a nondisplaced fracture at the medial posterior of the left femoral metadiaphysis.

R2's hospital orthopaedic consultation report dated 3/8/21 documents R2 who lives at a facility, fell and x-rays show a periprosthetic femur fracture around a left hip hemiarthroplasty. This report by V7, R2's Orthopaedic Physician documents V7 feels R2's surgical risk is too high

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and recommended nonoperative treatment with toe-touch weight bearing for four to six weeks.

R2's Final Report dated 3/12/21 for R2's fall on 3/8/21 at 11:50am documents R2 was admitted to the hospital with nondisplaced fracture of the left hip. This report also documents R2 did not receive surgical intervention and returned to the facility with toe touch weight bearing and orders for Physical Therapy and Occupational Therapy.

R2's Physician Progress Notes dated 4/6/21 document R2 was admitted to the facility on 3/11/21 following hospitalization for a left femur fracture. These notes document "Recurrent fall resulting in Left Periprosthetic Hairline Fracture."

On 4/21/21 at 3:49pm, V3, ADON stated V3 completed the investigation for R2's fall on 3/8/21 and R2 was independent. V3 stated the root cause was R2 lost R2's balance due to being "worked up" about discharge plans. V3 stated V3 could not remember if R2 was wearing R2's glasses at the time of the fall. V3 confirmed the investigation sheets document in one area R2 wears glasses but was not wearing them at the time of the fall and in another area R2 doesn't wear glasses. V3 stated V3 was not sure why the pressure alarms were implemented on R2's care plans to prevent falls on 3/23/21. V3 stated R2 does not have them now because R2 is wanting to go back to the assisted or independent living community. V3 was unsure why R2's care plans and care Kardex document R2 is to have pressure alarms to R2's bed and wheelchair or when they were discontinued. V3 confirmed the investigation documents R2 was ambulating independently when R2 fell. V3 stated therapy notifies nursing of resident's needing assistance

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with ADL's and that the staff should be reviewing each resident's Care Plans to see the level of assist the resident requires.

3.) R3's Care Plans dated 3/25/21 document R3 has a history of multiple falls. There is no "Goal" documented for R3's Fall Care Plan. R3's interventions to assist in preventing R3 from falling include pressure alarm in bed and chair and to make sure R3's call light is within reach and encourage use.

R3's Resident Fall Report dated 1/26/21 documents R3 was found on the floor at 3:30pm with R3's pressure alarm sounding. R3 stated R3 wanted to see R3's mother, walked and fell on the floor. This report documents the root cause of the fall as self transfer due to decline in cognition and confusion and forgetfulness. There is no fall risk category identified in this report. The intervention was to instruct to call for help before attempting activity by R3's self. R3's The Story of My Fall dated 1/26/21 at 3:30pm documents staff last assisted R3 at 3:00pm.

R3's Resident Fall Report dated 3/21/21 at 3:15pm documents R3 was found lying on the floor near R3's wheelchair. This report documents R3's pressure alarm was not sounding. R3 stated R3 was "walking over to the ironing board" and R3's leg gave out. This report documents a fall alarm was in use, but not sounding and was noted to be "plugged in but did not sound." There is no documentation the pressure alarm pad was evaluated or that the pressure alarm pads were being checked for function or replaced when expired. R3's The Story of My Fall documents the fall occurred on 3/21/21 at 3:00pm, which is 15 minutes prior to what is documented on R3's

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F 689	Continued From page 10	F 689		

Resident Fall Report for the same fall. This report documents the call light was not within reach and was on "the wall on one side of the room, (R3) was on the opposite side of the room." This report documents a chair alarm was in place, applied properly and functioning, which is not consistent with the Resident Fall Report for R3's fall on 3/21/21.

R3's Progress Notes dated 3/21/21 at 3:29pm document R3 was found on the floor. This note documents R3 was noted to have a 6cm (centimeter) x 6cm hematoma noted to R3's posterior cranium (head). This note documents R3's pressure alarm was plugged in, but did not sound when R3 stood up on R3's own unassisted. This note documents the pad was replaced, but does not document the pad or alarm box attached to the pressure pad was evaluated as to why it was not sounding.

On 4/21/21 at 11:00am, R3 was up in R3's wheelchair with pressure alarm in R3's seat of R3's wheelchair so the wheelchair pressure alarm pad was unable to be observed. V9, Registered Nurse (RN) retrieved R3's pressure alarm from R3's bed. R3's pressure alarm pad on R3's bed did not have the date the pad was installed on R3's bed or the expiration date documented on the pad. There is no documentation when this pad was placed or when it expires (needs to be replaced.) V9 stated V9 was unsure of how often the bed sensor pads were supposed to be replaced.

The undated label on the disposable bed sensor pad documents "90 day warranty" and to "write the pad's start date and warranty expiration date to track use." There are boxes labeled to write

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145400	A. BUILDING _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE	**2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11 "today's date" and "expiration date" on the top of the sensor pad. "Important Warnings It is important to implement and enforce the following warnings in order to keep all equipment functioning properly." Instructions for Set Up and Use: It is the responsibility of the facility to follow the instructions for set up and use carefully as outlined on this pad. At the end of the sensor pad's service life, the sensor pad must be disposed of." This device should not be a substitute for routine visual monitoring protocol by caregiving personnel." test the fall management system on a regular basis to ensure proper operation. The disposable sensor pad is warranted for singe resident use for the warranty period specified (in days) on this pad. The warranty starts from the date the pad is installed on the patient's bed or chair. The facility's Fall Prevention Policy dated February 2021 documents the policy is to assist in minimizing injuries related to falls and decrease falls. This policy documents Fall assessments are to be completed by the nurse on day of admission, quarterly and with change of condition and reviewed after each fall. All employees must observe residents for safety. The facility's Falls - Clinical Protocol dated August 2020 documents the physician will help identify individuals with a history of falls and risk factors for subsequent falls. The nurse shall assess and document/report information including vital signs and musculoskeletal function. The physician will identify medical conditions affecting fall risk and the "risk for significant complications of falls (for example, increased fracture risk in someone with osteoporosis...)" For a resident who has fallen, staff will attempt to identify possible causes.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 12 Causes refer to factors that are associated with or that directly result in a fall. The staff will collect and evaluate information until either the cause of the falling is identified or it is determined the cause cannot be found or finding a cause would not change the outcome or management of falling and fall risk. Based on the assessment the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.	F 689		