STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145598	A. BUILDING _____ B. WING _____	C 04/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY MANOR	**2345 NORTH SEMINARY STREET GALESBURG, IL 61401**

(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 000	INITIAL COMMENTS Complaint Investigation 2122245/IL132389	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.	F 580		4/12/21

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

Electronically Signed | 04/22/2021

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 580	Continued From page 1 (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify a resident's representative for a change in condition for one (R1) of three residents reviewed for change in condition in a sample of three. Findings include: Facility Change in a Resident's Condition revised 12/02 documents "Our facility shall promptly notify the resident, and or resident's representative and his or her attending physician of changes in the resident's condition and or status. 2. The nurse will notify the resident's representative when: b. There is a significant change in the resident's physical, mental or psychosocial status." R1's medical record focused respiratory assessment dated 3/29/21 documents "Rhonchi lung sounds with productive cough." R1's medical record dated 3/29/21 at 9:50 am	F 580	Plan of Correction Seminary Manor Provider #145598 Survey Date April 12, 2021 Complaint 2121992/IL32090 Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider to the allegations or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. None of the actions taken by the facility pursuant to its Plan of Correction should be considered an admission that a deficiency existed or that additional measures should have been in place at the time of survey. F580 1. Corrective action which will be	

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	145598	A. BUILDING _____ B. WING _____	C 04/12/2021

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F 580	Continued From page 2 documents "Doctor noted cough with new order to obtain chest x-ray. Send to emergency room if worsens." R1's medical record dated 3/29/21 at 10:05 AM, documents "Mobile x-ray here and completed chest x-ray. Waiting on results." R1's medical record does not document R1's representative was notified of the chest x-ray. R1's medical record dated 4/4/21 at 8:20 PM documents "Positional dependent edema noted from knuckles up approximately half way on right hand from laying on right side. Resident reports some tenderness around 3rd and 4th digit. Hand grasps within normal limit. Some bruising noted from previous fall, no new areas of concern noted. Resident states that he does not remember injuring hand, bumping hand or hitting hand on anything today. Staff reports no injuries that are known. Medical Doctor notified, awaiting response." R1's medical record dated 4/5/21 at 6:02 PM, documents "Doctor response back to resident having swelling to right hand with get an x-ray of hand." On 4/8/21 at 11:17 AM, V4, R1's power of attorney (POA), stated "I was not informed (R1) was getting an x-ray of his right hand." On 4/8/21 at 12:25 PM, V1, Administrator, verified R1's POA was not notified of change in condition and stated "(R1)'s POA should have been notified of the chest and hand x-ray."	F 580	accomplished for those resident found to have been affected by the Deficient practice: On 4/12/2021 R1□s is no longer in the facility. 2. How the facility will identify other residents having the potential to be affected by the same practice: Seminary Manor has identified all residents as being at risk for lack of notification. The facility has reviewed all those with changes in condition for notifications being done as appropriate. 3. The measure the facility will take to ensure that the problem will be corrected and will not occur: All staff, Clinical and MDS staff were in-serviced on 4/12/21 on any resident change of condition must be communicated to physician and resident representative. Those residents at risk or with a change in condition will be reviewed at a minimum daily in the standup meeting per each occurrence. The IDT Team will review resident change in condition and notification are done appropriately daily and implement corrective action as appropriate. 4. Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON and/or designee will audit 2 residents per week for four weeks to ensure proper documentation including Events, new orders and change in condition for notifications in place. This information will be incorporated into facility□s Quality Assurance Program.	

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F 580	Continued From page 3	F 580	5. Dates when corrective action will be completed: 4/12/2021	
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 ensure resident's bed was in low lying position for one (R1) of three residents reviewed for falls. This failure resulted in R1 sustaining a right-sided subdural hematoma and scattered subarachnoid hemorrhages and subsequently death. Findings Include: R1's care plan dated 2/20/21 documents, Problem: Resident (R1) at risk for falling r/t (related to) recent illness/hospitalization and new environment. (R1) has hx (history) of falls. (R1) has a dx (diagnosis) of dementia, poor safety awareness and is impulsive. Res (resident) has impaired balance and mobility related to weakness and confusion ...." Goal: Resident will have decreased risk for injury related to fall this quarter. Approach: Low bed and scoop mattress." R1's fall risk assessment dated 3/21/21	F 689	Plan of Correction Seminary Manor Provider #145598 Survey Date April 12, 2021 Complaint 2121992/IL32090 Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider to the allegations or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. None of the actions taken by the facility pursuant to its Plan of Correction should be considered an admission that a deficiency existed or that additional measures should have been in place at the time of survey. F689	4/12/21

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F 689	Continued From page 4 documents R1 as a high fall risk. On 4/08/21 at 10:00 AM, V6, Care Plan Coordinator, stated "One of the fall interventions for (R1) was for the bed to be in a low position. (R1) has a history of getting up from his bed and walking without assistants or calling for help" R1's medical record documents R1 fell four times with two falls, 3/21/21 and 4/05/21, resulting in serious injuries. R1's medical record dated 3/21/21, documents "(R1) fell hitting face. Laceration, broken teeth and bruising with skin tear. Sent to emergency room for evaluation and sutures." R1's hospital records dated 3/21/21 documents "Imaging report: computerized tomography (CT) scan brain. Impressions: No evidence of acute intracranial hemorrhage." R1's medical record dated 4/5/21 documents "At 7:15 PM, Certified Nursing Assistant (CNA) called this nurse to (R1)'s room. When entering the room, (R1) was noted to be laying on his left side on the floor by his bed. Bed was up in a normal position and call light was not on. (R1) stated "I fell out of my bed." (R1) noted to have laceration to back side of left head. Pressure applied and bleeding did slow down. On call doctor notified and new order to send to emergency room for treatment." R1's hospital record dated 4/5/21 at 9:36 PM documents "Imaging report: CT scan brain. Findings: Scattered subarachnoid hemorrhages are seen within the right temporal lobe and frontal lobe. Hemorrhagic contusions in the right	F 689	1. Corrective action which will be accomplished for those resident found to have been affected by the Deficient practice: On 4/12/21, R1 is no longer in the facility. 2. How the facility will identify other residents having the potential to be affected by the same practice: Seminary Manor has identified all residents with moderate to high scoring on the John Hopkins Risk Assessment as being at risk for falls. The facility has reviewed Assessment/Observations for those residents identified. Those resident charts have been audited for completion and updates as appropriate. 3. The measure the facility will take to ensure that the problem will be corrected and will not occur: Clinical and MDS staff were in-serviced on 4/5; 4/9; 4/12 on Falls, supervision of vendors at bedside, completion of documentation including Events, Root Cause Analysis, identification of trends and patterns, to assist in fall Prevention, supervision as specific to individual resident needs. Those residents at risk or have fallen will be reviewed at a minimum daily in the standup meeting per each occurrence. The IDT Team will review interventions, determine Root Cause, assess for trending and patterns, and make changes as appropriate. 4. Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are	

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F 689	Continued From page 5 temporal parietal lobe are visualized. There is a small right-sided subdural hematoma measuring up to seven millimeters. Bilateral periventricular white matter changes are seen suggesting microangiopathic ischemic changes." R1's hospital records dated 4/6/21 documents "(R1) presents as a transfer from outside hospital after unwitnessed fall at the nursing home. He was found to have a subdural hematoma as well as subarachnoid hematoma. during transfer, he had two seizures." On 4/8/21 at 9:00 am, V2, Director of Nursing (DON), stated "Mobile x-ray came in to get an x-ray of (R1)'s hand and left his bed in the raised position. (R1) fell out and sustained a subdural hematoma." On 4/8/21 at 12:25 AM, observation of R1's bed appeared approximately six inches from floor. V2, DON, stated "That's the low-lying position. (R1)'s bed was in a raised position at the time of the fall." Observation of bed in raised position is approximately three feet off the floor. On 4/8/21 at 12:35 PM, V1, administrator, stated "The x-ray tech took an x-ray of R1's right hand, exited the room and left R1's bed in the raised position. R1 wound up falling out of the bed causing a head injury." On 4/9/21 at 11:09 AM, V3, CNA, stated "I was working on 4/5/21 assigned to (R1)'s group. That evening I got (R1) cleaned up and placed him in bed. The mobile x-ray technician came in to take an x-ray of (R1)'s hand and asked me to raise the bed to a high position, so I raised (R1)'s bed up for the X-ray. It's not mandatory to stay in the	F 689	permanent: DON and/or designee will audit 2 residents per week for four weeks to ensure proper documentation and supervision of vendors at the resident bedside to ensure resident safety protocols are maintained, Interventions are in place, and reflect individual needs. This information will be incorporated into facility□s Quality Assurance Program. 5. Dates when corrective action will be completed: 4/12/2021	

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F 689	Continued From page 6	F 689		

room with them, but I always do. During the x-ray, a call light in another room went off and so I asked the x-ray technician if it was ok to answer the call light. He said yes. So, I left the room to answer another call light. When I came out of the room from answering the call light, I heard (R1)'s roommate hollering "We need help." When I entered (R1)'s room, the x-ray technician was gone, (R1) was lying on the floor between the beds, and the bed was still in the raised position."

On 4/13/21 at 1:55 PM, V5, x-ray technician, stated "I was called in to take an x-ray of (R1)'s hand. When I got there a nurse told the CNA to give me a hand. We walked into the room and the bed was in a low position, I didn't know where the controls were, so I asked the CNA to raise the bed in order for me to get my machine under the bed. The CNA raised the bed. I told the CNA I was good because I only had three x-rays to get. She left the room; I finished the x-ray and left the room. I did not put the bed back down because it wasn't that far off the floor. When I left, the CNA that was in the room with me, was in the hallway, so I told her I was all done and needed let off the unit because it's a locked unit. She let me out and I left."

On 4/12/21 at 9:00 AM, V1, Administrator stated "We don't have a fall prevention or fall risk policy. We do the fall assessment and put the fall interventions on the care plan." V1 also stated that there currently is no policy addressing x-ray technicians while on site.

R1's medical record dated 4/11/21 documents that (R1) expired in the hospital.

R1's death certificate lists Date of Death April 10,

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F 689	Continued From page 7 2021; cause of death a. Traumatic Subdural Hematoma with Subarachnoid Hemorrhage b. Fall.	F 689		