STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145062	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Streator	1525 East Main Street Streator, IL 61364

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34048 Based on interview and record review the facility failed to provide supervision and implement fall interventions for a resident at risk for falls for one resident (R1) of three reviewed for falls in a sample of three. This failure resulted in R1 sustaining multiple falls and acquiring a displaced fracture of the left lesser trochanter. Findings include: The facility's Fall Prevention Program, dated 10/2024, documents the facility is to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. R1's Fall Risk Assessment, dated 11/19/24, documents that R1 is at risk for falls. R1's Comprehensive Incident Fall Assessment, dated 11/8/24, documents that R1 was sitting on the floor next to her bed. R1 stated that she was trying to go to breakfast. R1 didn't realize it was bedtime. This form documents that safety interventions are already in place. No new fall interventions were implemented. R1's Comprehensive Incident Fall Assessment, dated 11/10/24, documents that R1 was sitting on the floor with her back against her roommate's recliner. R1 stated that she was walking out of the bathroom without her walker or wheelchair, tripped over the catheter bag. R1's skin assessment documents a skin tear 3.7cm (Centimeters) on her right shin and a 5cm by 1.1cm skin tear on her right forearm. No new immediate fall interventions were put into place. R1's Comprehensive Incident Fall Assessment, dated 11/12/24 at 10:15am, documents that R1 was yelling out for help. R1 was sitting on her buttocks on the floor upon entering the room. R1 stated that she was getting up for lunch and fell . R1's call light was off. R1's wheelchair with her catheter bag was next to R1. R1 sustained a 2cm by 2cm lump and a bruise to her left forehead. R1 also sustained a 0.5cm by 0.2cm bruise to her left elbow and a 4cm by 4cm skin tear to her left lower extremity. R1's fall intervention was to keep R1 within nurses' sight. (continued on next page)

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

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(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 - Actual harm Residents Affected - Few	R1's Comprehensive Incident Fall Assessment, dated 11/30/24 at 11:00am, documents that V5 (Registered Nurse/RN), and V6 (RN) and V7 (Licensed Practical Nurse/LPN), were at the southwest nurses' station when they heard a loud yell, upon exited the nurses' station, R1 was noted lying on her back on the floor in the middle of the southeast hallway. Upon assessment R1 was eliciting pain to her left hip area with movement. R1 was able to move all other extremities without difficulty. R1's left hip was maintained in a neutral position, denies pain everywhere except her left hip. V11 (R1's Power of Attorney) was notified and requested that R1 be sent to the emergency room for an evaluation. R1's left hip/left femur x-rays, dated 11/30/24 at 1:23pm, documents an acute minimally displace fracture involving the left femur lesser trochanter with suggestion of extension through the femoral neck. R1 will be transferred to another hospital for further management. R1's Hospital Course/Reason for Admission, dated 12/5/24, documents that R1 had a left hip fracture, status post left hip cephalomedullary nailing on 12/2/24. R1's Progress Notes, dated 12/5/24, documents that R1's left hip has three incisions with staples 13 in one, 6 in another and 5 in the third. R1's incision remains well approximated with no signs and symptoms of infection. On 12/18/24 at 9:00am, V5 (RN) stated that attempts were made to keep R1 within sight while she is up in the chair. V5 stated that R1 was following staff down the hall, while they were doing care. V5 was not sure why R1 was left alone in the hall. On 12/18/24 at 9:30am, V8 (Certified Nursing Assistant/CNA), stated that she was in a room providing assistance to another, when she heard R1 yell. V8 stated that she ran out and R1 was on the floor. V5, V6 and V7 were already running to R1. V8 stated that R1 was attempting to get up and down most of the morning. V8 also stated that R1 was confused, mumbling for a few days prior to her fall. V8 stated that staff try to sit with R1, but it is hard to do when staff are on breaks, and call lights are going off. V8 verified that she was the only one CNA on the floor at the time of the fall. V8 also stated that V5, V6 and V7 were at the nurses' station for report and shift change. On 12/18/24 at 10:10am, V6 (RN) stated that she was at the nurses' station and heard R1 yell. V8 stated that R1 was on the floor in front of her wheelchair. V6 stated that when R1 is anxious, attempts are made to keep her at the nurses' station and within arm's reach. V6 verified that R1 was unable to be redirected. On 12/18/24 10:20am, V2 (Director of Nursing) stated that R1's Fall Risk Assessment, dated 11/19/24, is inaccurate. V2 verified that R1 was a high risk for falls. On 12/18/24 at 10:45am, V9 (CNA) stated that R1 was wandering everywhere on the day she fell . V9 verified that she was on break at the time of R1's incident. V9 verified that during breaks there is only one CNA on the unit to answer call lights and provide care.