STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145546	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Zion Health & Rehab Center	1225 Woodland Drive Mount Zion, IL 62549

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** 31642 Based on record review and interview the facility failed to provide a dependent resident, who is a two-person assist, a safe transfer in order to prevent a fall. This failure affected one of seven residents (R1) reviewed for falls/safe transfer on the sample list of seven. Findings include: R1's Minimum Data Set, dated dated dated [DATE] documents the following: R1's usual activity performance is 5. C (coded 2), Toileting Hygiene- current level of care, Substantial to Maximal Assistance-Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half effort and 5. D (coded 2) Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed, Substantial to Maximal Assistance-Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half effort. R1's Hospice Care Plan dated 3/16/24 documents the following: R1's Hospice Plan of Care documents: Brief Narrative Statement '(Review the individual's clinical circumstances and synthesize (combine) the medical information to provided clinical justification for Hospice Serviced)'. (R1) for initial hospice primary diagnosis is Chronic Myelocytic Leukemia (Cancer). Significant comorbidities include COPD (Chronic Obstructive Pulmonary Disease) with oxygen dependency, Diabetes, and Hypertension.(R1) was diagnosed with Chronic Myelocytic Leukemia in November 2023. R1 was initiated on Chemotherapy but had a rapid decline. 6 (Six) months ago, she was able to care for herself. She is no longer able to bear weight. She is now discontinued care with chemotherapy and wishes to enroll in Hospice. She has had a 42 pound weight loss over the last 6 (six) months. She is on oxygen at 2.5 l (liters per minute) by nasal cannula continuously. Patient has had worsening appetite and is currently sleeping most of the day. She is DNR (Do Not Resuscitate) This Care Plan and narratives are signed by V9, Hospice Physician on 3/21/24. R1's same Care Plan documents: Safety Measures For Dyspnea, Fall Prevention, Impaired Vision, Infection Control, Medication Safety, Oxygen Safety, and Diabetic Precautions. (continued on next page)

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.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's same 3/16/24 Hospice Plan of Care documents: Patient/Caregiver will demonstrate safe transfers using proper body mechanics and equipment throughout the episode. Patient/Caregiver will verbalize demonstrate effective home safety and fall prevention measures and strategies as evidenced by patient will remain free from injury throughout this episode. along with Activities Permitted: Complete Bedrest. as well as Mental Status: Forgetful and Lethargic. R1's Facility Care Plan dated 4/8/24 documents the following: Focus: I have (sic) I am at risk for an ADL (Activity of Daily Living) Self Care Performance Deficit r/t (related to) Fatigue, Impaired balance, Pain. Goal: I will maintain current level of function in bed mobility, transfers, eating, dressing and toilet use and personal hygiene; through next review date. Interventions: Toilet Use: (R1) requires two staff participation to use toilet. Date initiated 11/23/22. Transfer: (R1) two person assist with transfers. Date initiated 11/23/22. R1's Witnessed Fall investigation report: signed by V3 (Licensed Practical Nurse), whom no longer works for the facility, dated 4/14/24 at 1:15 am. documents the following: Incident Description, Nursing Description: Resident lying on floor face on the floor, bleeding from nose, bruise to forehead and skin tear to left forearm resident reports requesting to get in chair and go to restroom. Resident Description: Resident reports requesting to get in chair and go to bathroom, V5 (Certified Nursing Assistant) assisted R1 into wheelchair, while sitting up in wheelchair R1 felt dizzy and fell forward, R1 c/o (complained of) headache, reports no longer feeling dizzy. The same report documents R1's Mobility: Wheelchair bound. The same report documents the pre-disposing factors identified with a checkmark included R1 was Drowsy and Weakness/Fainted. The final interdisciplinary note at the bottom of the Witnessed Fall Investigation Report, dated 4/15/24, documents the following: Current interventions in place and staff was present during the incident but were unable to prevent the fall safely. The resident was attempting to get out of bed and use the restroom with a (solo) member. R1 has not gotten out of bed much recently due to her declining condition and end of life care. Staff member assisted but resident fell forward related to her poor trunk strength and being dizzy. Staff assisted her with completing toileting needs as the immediate intervention. IDT determined that two staff members will assist R1 with cares as an intervention r/t (related to) decline in strength and condition. V20 (Primary Care Physician), V19 (Power of Attorney) and V8 (Hospice Registered Nurse) aware. Care Plan updated. R1's facility care plan 4/8/24 had already documented R1 required two person assist with transfers and toileting on R1's ADL care, which was initiated 11/23/22. R1's fall prevention on the same facility care plan, did not have a transfer status documented until 4/15/24. On 4/30/24 at 2:10 pm V19 (Power of Attorney) confirmed she was notified of R1's fall 4/14/24. V19 stated they were informed R1 fell forward out of her wheelchair while being changed and landed on her face. V19 also stated R1 had been incontinent for over a year. R1 was on Hospice and was very weak. R1 stayed in bed. V19 said they did not know why the facility did not provide incontinence care in bed at that time of night (midnight). R2's Minimum Data Set, dated dated dated [DATE] documents R2's Brief Interview of Mental Status score of 15, out of a possible 15, which indicates no cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 3:47 pm R2 confirmed R1 resided in R2's room at the time of R1's fall 4/14/24. R2 stated I saw it all. R1 was my best friend before we moved in here (into the facility). It was 12:00 o ' clock at night when R1 fell . I don't know that I have ever known V5's(Certified Nursing Assistant) name. I don't think we had our call light on. R1 usually got changed in bed. That night V5 put R1 on the side of the bed. We never had our privacy curtain closed. Usually, if R1 was dizzy, she would put her hands down on each side of herself. That night she put her hands down, she was dizzy. Rarely would she say anything. She did not tell V5 that she was dizzy. There was only one CNA(Certified Nursing Assistant) assisting her. Prior to the fall they used two people most of the time. That night it was just one girl. So, V5 stood R1 up, and walked R1 backwards, and attempted to put R1 in the wheelchair. V5 did not have the wheelchair locked. As she tried to put R1 in the wheelchair, the wheelchair was going backwards. V5 did get her into the wheelchair, but R1 was not all the way back on the wheelchair seat. She was more forward in the chair then back where should have been. V5 turned away from R1, and no sooner did V5 turn away, R1 fell face forward out of the wheelchair onto the floor just a few feet from R1's bed. There's still blood from R1's nose on the floor. At this time, the surveyor observed as R2 moved her motorized wheelchair and pointed to a dark burgundy half -dollar to silver dollar sized spot on the light brown carpet. R2 stated The spot is just outside the closed bathroom door. R2 also stated The bathroom door was not open at the time of the fall. R1 had gone to bed between 9:00 pm and 10:00 pm. She usually sleeps through the night and staff check us to see if we are wet. During the day, before she got sick, she could use the bathroom, but she did not get up at night. They changed her in bed. V5 got another CNA(Certified Nursing Assistant), (unidentified), after R1 fell . They were stepping over R1. They were just laughing and talking to each other, not to R1. It was so inappropriate. They were so disrespectful. That is the worst of it all. R1 was such a kind person. I was so upset I was crying. I think they brought the mechanical lift in. I was really upset. It is all a blur to me after that. After that fall she just laid in bed. Before that, she might be put in her chair to change her bed linens then put her right back in the bed. Just to look at R1 with her face, all bruised, broke my heart. I can block things out of my mind, but I don't remember anyone asking me what I saw happen. I would have told them exactly as I am telling you. On 5/2/24 at 1:17 pm V17 (Director of Business Development/Liaison) was the manager on duty when R1 fell . R2, was on her scooter (motorized wheelchair). I had R2 come to her room for privacy. She had asked to speak to me that next morning. It was around 9:30 am on 4/14/24. R2 told me that R1 had fallen. R1 was in bed, drifting in and out of sleep while I was talking to R2. R2 was crying and said that R1 and R2 were like sisters. R2 said she saw R1's fall. R2 was not sure if V5 locked R1's wheelchair. V5 was having a hard time getting R1 in the wheelchair and the wheelchair kept moving. R2 said because of the wheelchair moving, R1 got really dizzy. I asked R2 how she knew R1 was dizzy. R2 said R1 had her hands on each side of herself, on the bed, before the transfer. On 5/2/24 at 1:55 pm V2 (Director of Nursing) reviewed R1's fall investigation dated 4/14/24 and associated care plan interventions. V2 confirmed V5 was the only CNA that completed R1's transfer, R1 was supposed to be on complete bedrest according to plan of care due to lethargy and should have had two staff assist with any necessary transfers prior to R1's fall 4/14/24. On 4/5/2024 at 3:20 pm V1 stated Hospice plan of care is incorporated into the resident facility care plan. The facility policy Accidents and Incidents dated dated 07/01/2023 documents the following related to implemented appropriate interventions: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Investigate and follow up Action: E. The D.O.N, IDT, and/or Designee will conduct an investigation of the accident/incident as well. Findings will be indicated in the appropriate area. The IDT will review with in 24 hour or next business day and discuss and attempt to find out the root cause and implement an appropriate intervention to attempt to prevent further falls.