

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/26/2024
NAME OF PROVIDER OR SUPPLIER  Aviston Countryside Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  450 West 1st Street Aviston, IL 62216	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33110</p> <p>Based on observation, interview, and record review, the facility failed to provide proper supervision to prevent falls for 1 of 7 residents (R45) reviewed for supervision to prevent accidents in the sample of 28.</p> <p>Findings include:</p> <p>1. R45's Face Sheet documents she was admitted on [DATE] with the diagnosis of Orthostatic Hypotension.</p> <p>On 6/23/24 at 9:30 AM R45 has purple bruises to her face around her left eye and a bruised purple underneath her right eye. R45 has purple linear bruises on her neck. R45 stated I had to pee, I thought I could do it, but I hadn't taken my Midrin and I got dizzy and fell from the commode.</p> <p>R45's Physician Order Sheet dated 1/17/24 documents STAT (immediate) cardio referral.</p> <p>R45's Administrative Note dated 1/17/24 documents Called (local) Cardio referring to STAT Cardio referral. Waiting for a call back to schedule appointment.</p> <p>Administrative Note, dated 1/25/24, documents Got in contact with (A local hospital) Cardiology regarding Cardio referral. Faxing all information over and office will review and contact R45 or myself (V11) to schedule an appointment. Phone: (office phone numbers and office fax numbers).</p> <p>R45's Nursing Note dated 1/27/24 documents Resident seen by NP (Nurse Practitioner) with new order Diclofenac gel 1% 4G to L knee 4 x (times) daily PRN (whenever necessary). Draw CBC (complete blood count), BMP (Basic metabolism Panel), lipid panel, vit (vitamin) D, A1C. Obtain orthostatic BP (blood Pressure) daily 3 days, send results. There was no documentation regarding the Cardiology referral.</p> <p>R45's Minimum Data Set (MDS) dated [DATE] documents for transferring R45 requires partial to moderate assist, and when going from sit to stand she is a substantial/maximal assistance.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R45's Care Plan dated 1/27/24 documents Resident is at risk for falls due to weakness 1/27/2024 assisted to floor by nurse and 6/2/2024 fall in room. R45's Care Plan Interventions documented Order comprehensive medication review by pharmacist, assess for polypharmacy and medications that increase the fall risk which was created on 1/29/24. The following approaches documented 1/29/24, Assessment and treatment for postural/orthostatic hypotension; 1/29/24, Provide individualized toileting interventions based on needs/patterns; 1/29/24, Resident educated to use her call light and wait for staff assistance; 3/4/24, Falling star program initiated; 6/2/24, Send to ER evaluation as ordered; and 6/2/24, Resident to use her call light and ask for staff assistance when feeling dizzy. R45's Care Plan did not address R45's orthostatic hypotension and what approaches staff should use to address this problem.</p> <p>R45's Safety Events Event Report Fall and Investigation dated 1/27/24 documents resident fell this morning while transferring to BSC (Bedside Commode) This nurse was assisting resident to BSC and caught resident when she fell and assisted her to the ground no injury noted.</p> <p>R45's 6/2/24 Nurse's Note documents Res (resident) observed lying face down on bedroom floor with BSC (bedside commode) to R (right) of her. Res stated she became dizzy and fell forward off of BSC onto floor. Dark purple hematoma to L eye. Gait belt on place, gripper socks in place. Res c/o (complained of) of generalized discomfort. Transferred with 2 assist and gait belt back to BSC as resident requested. CNA (Certified Nursing Assistant) remained with resident. Writer notified PCP (Primary Care Physician) and called EMS (Emergency Medical Service) for transport to Local Hospital Emergency Department) r/t (related to) fall with hematoma to L eye and use of Eliquis &amp; Plavix. Awaiting arrival of EMS. Report called to (Local Hospital Emergency Department) at this time. Awaiting EMS arrival. Nurses note dated 6/3/24 documents Resident returned from (Regional Teaching Hospital following fall with hematoma to L eye. Res was under observation during hospitalization . Returned via EMS with 2 attendants, transferred from stretcher to bed with 2 assists of EMS. Res A&amp;O (Alert and Oriented) x4, able to make needs known. Res to f/u (follow up) with Ophthalmologist per discharge instructions. Plavix and Eliquis on hold x 5 days, then may resume. Discharge orders/instructions reviewed. Re-admission assessments completed. PCP Primary Care Physician notified of return. Will continue current POC (Plan of Care).</p> <p>R45's Safety Events Event Fall and Investigation dated 6/2/24 documents resident observed lying face down on bedroom floor with BSC to the right of her. Resident stated she became dizzy and fell forward off the BSC onto the floor. Dark purple hematoma to left eye gait belt in place gripper socks in place. Resident complained of generalized discomfort transferred with 2 assist and gait belt bake to BSC as resident requested Vital signs CNA (Certified Nurse's Assistant) remained with resident EMS (Emergency Medical System) transported to Local Hospital emergency room ) related to fall.</p> <p>R45's Physician Order Sheet dated 6/24/24 documents referral to cardiology r/t (related to) orthostatic hypertension.</p> <p>R45's Administrative Note dated 6/25/24 documents faxed cardiology referral to (local) Cardio. Will call office to f/u (follow up). Will notify resident, family, and physician.</p> <p>R45's Fall Risk assessment dated [DATE] documents R45 is a moderate risk for falls.</p> <p>On 6/25/24 at 3:16 PM V12 Physician stated, Maybe she became bradycardic I don't see that they could have done anything different if she asked for privacy.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/25/24 at 2:00PM V18 CNA stated, that morning she rang to get her on the commode. She is a two person assist. Me (V18) and (V19, CNA) got her on the commode. She likes her privacy, so I gave her the call light and left to go across the hallway to help another resident I heard all of the commotion. I heard later what happened.</p> <p>On 6/26/24 10:00 AM V2 Director of Nursing stated, If I know a resident had falls at home or has a high score on the John Hopkins fall assessment, we put them on the falling stars program. It just indicates the resident is high risk for falls. They called her back about the cardiology appointment and she declined. She likes to go out to eat but she does not like to leave the building.</p> <p>R45's Electronic Health Record was reviewed, and a refusal to go to cardiology was not documented.</p> <p>On 6/26/24 at 11:00 AM V5 Licensed Practical Nurse, LPN, stated, I entered the room. She (R45) was lying on the floor. I assessed her (R45), and she complained of generalized pain. Her (R45) vital signs were normal. She (R45) stated she got dizzy and fell from the bedside commode. Her eye was bruised, and she (R45) had a hematoma. No, I wouldn't expect the staff to stay with her if she asked for privacy. Yes, I did know she had Orthostatic Hypotension. We assisted her back to the bedside commode. We sent her out due to blood thinners.</p> <p>On 6/26/24 at 12:05 PM V19, CNA stated, I got her up and put her on the bedside commode. She (R45) asked me to give her, her phone, because she had to do number two. I gave her the call light and the telephone, and left the room, because she is alert and oriented. She stated she got dizzy and fell from the commode.</p> <p>Facility policy, updated July 2014, documents It is the policy of (the facility) to decrease the number of falls in the facility. The Fall Program is designed to facilitate recognition of residents that are at a high risk of falls. Residents will be placed in the Fall Program if their fall risk assessment identifies them at high risk, or if determined by the interdisciplinary team.</p>		