| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145785 | A. Building<br>B. Wing | 10/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bria of Mascoutah | 901 North Tenth Street<br>Mascoutah, IL 62258 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156<br><br>Based on interview and record review the Facility failed to ensure progressive interventions were being implemented for 1 of 3 residents (R2) reviewed for falls in the sample of 6.<br><br>Findings include:<br><br>R2's Physician Order Sheet for October 2024 documents a diagnosis of encephalopathy, chronic obstructive pulmonary disease (COPD), hemiplegia affecting left non dominant side, cerebral infarction, diabetes, weakness, pain in right hip, unspecified convulsions, schizoaffective disorder, unspecified dementia, and unspecified psychosis.<br><br>R2's Minimum Data Set, (MDS) dated [DATE] documents R2 was moderately impaired for cognitive impairment for decision making of activities of daily living. R2 requires use of a wheelchair. R2 requires moderate assistance with showering and personal hygiene. He requires set up for eating, oral hygiene, upper and lower body dressing and taking off and applying footwear. R2 also has a (urinary) catheter and is frequently incontinent of bowel.<br><br>R2's Fall risk evaluation dated 8/25/2024 at 6:07 PM documented that R2 is a high risk for falls.<br><br>R2's Progress notes dated 8/25/2024 documented a certified nursing assistant, (CNA) heard a thud from resident's room, immediately went to see and found resident on the floor up against the door. R2 appeared to hit head and stated a little pain. R2 unable to recall what happened.<br><br>R2's Progress notes dated 8/25/2024 at 5:30 PM document Visit Type: Sound physician telehealth. Details: Chief complaint: Fall. Saw patient on video with staff. Patient had an unwitnessed fall. He denies any pain and no visible injury per staff. he is on Plavix (blood thinner). (R2) thinks he hit his head, but staff did not feel any bumps/bruises on his head. No headache.<br><br>R2's Incident Report dated 8/25/2024 at 5:10 PM, documents, CNA heard a thud from resident's room, immediately went to see and found resident on the floor up against the door. Resident appeared to hit head and states a little pain. Resident unable to recall what happened. Resident was lying in bed watching TV and then I was on the floor. I am not sure what happened. R2's Incident Report does not document any fall interventions for this fall and/or any future fall preventions for any future falls.<br><br>(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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145785 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/03/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Bria of Mascoutah | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 North Tenth Street Mascoutah, IL 62258 | |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R2's Progress notes dated 8/26/2024 at 8:00 AM document (R2) was observed on floor in his room, next to his bed and nightstand. Positioned on his back with legs outstretched. R2 is unable to state what happened. Mental status and ROM (range of motion) both at his baseline. Assessed for pain/injury, none noted at this time. Stated he hit his head. Nurse practitioner, (NP) in facility, assessed resident and requested he be sent to ER (emergency room ) for evaluation.<br><br>R2's Progress notes dated 8/26/2024 at 5:46 PM documented R2 returned from local ER at 3:00 PM and was started on antibiotics.<br><br>R2's Fall Incident Report dated 8/26/2024 at 8:00 AM, documents, Resident found lying on floor in his room next to bed and night stand. Positioned on his back with legs outstretched. Unable to state what happened. Mental status at his baseline. ROM (range of motion) at baseline. NP (Nurse Practitioner) examined resident, and requested he be sent to ER for evaluation. Resident unable to give description. R2's Incident Report does not document any fall interventions for this fall and/or any future fall preventions for any future falls.<br><br>R2's Progress notes dated 8/30/2024 at 7:42 PM documented nurse was in the hallway preparing medications for medication pass, when she heard a loud noise at 7:42PM. She looked down the hallway and saw the resident laying on the floor on his back with his lower half of his body in his room and the upper half of his body in the doorway to his room and his head on the hallway floor. At 7:45 PM VS (vital signs) (97.7, 68, 16, 111/45, 98% on RA). Neuro checks done at 7:46 PM with all being within normal limits. (R2) stated he didn't know what had happened, but that he did hit his head. Small laceration measuring approximately 0.5cm (centimeters) with a small amount of blood noted. (R2) denied any pain or discomfort at that time. At 7:51 PM, this nurse called 911 for EMS (emergency medical service). At 7:52 PM, this nurse called (R2's) power of attorney, (POA) but he did not pick up the telephone and a voice message was left to contact the facility. At 7:53 PM, this nurse contacted the facility administrator. At 7:56 PM, this nurse called resident's #2 contact, and she did not pick up the telephone and no message were left by this nurse at that time. At 7:59 PM, resident's POA (Power of attorney), returned this nurse's phone call and report was given to POA about incident and R2's condition. This nurse also informed POA of facility's bed hold policy and that the resident was informed of bed hold policy and given a copy along with his other paperwork that was given to emergency medical staff, (EMS) staff. POA verbalized understanding. At 8:00 PM, EMS arrived at this facility and placed resident on the stretcher. At 8:04 PM EMS left the facility with the resident to transport him to local hospital's ER for evaluation. Also, at 8:04PM, local hospital ER was contacted, and report was given to hospital nurse regarding R2's condition and that he did not receive the ordered 8:00 PM medications as he fell prior to administration by this nurse.<br><br>R2's Incident Report dated 8/30/2024 at 7:42 PM, documents, Resident up and ambulating in his room, resident heard falling and was found with his lower half of his body inside his room while the upper half of his body was out in the hallway. This nurse heard a loud noise and looked down the hall and saw the resident laying on his back. Resident stated he didn't know what happened. Resident did say he hit his head. Resident was ambulating without assistance. The Incident Report does not document any fall interventions for this fall and/or preventions for any future falls.<br><br>R2's Progress Notes dated 9/11/2024 at 12:53 AM, Resident fell and got himself up and onto the bed. Resident stated he hit the right, back side of his head. Resident states that he is unsure of how he fell . ROM (range of motion) WNL (within normal limits). NP made aware and gave order to send resident to ER due to resident being on an anticoagulant.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Bria of Mascoutah | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 North Tenth Street Mascoutah, IL 62258 | |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R2's Care Plan for Falls documents R2 incurred a fall on 8/25/2024, 8/26/2024 and 8/30/2024. The interventions on the Care Plan for the Fall on 8/25/2024 documents, resident unaware how fall occurred. Resident with UTI (urinary tract infection), started on antibiotics. R2's fall on his Care Plan on 8/26/2024 2024 interventions documents, resident unaware how fall occurred. Resident with UTI (urinary tract infection), started on antibiotics. R2's Care Plan fall on 8/30/2024 resident unaware how fall occurred. Resident with UTI (urinary tract infection), started on antibiotics. (All three of R2's falls documented the same interventions, and no new and/or progressive interventions were documented). R2's Care Plan does not address his fall on 9/11/2024.<br><br>On 10/03/2024 at 10:50 AM, V4, Assistant Director of Nursing (ADON) stated she was called down to the hallway after a CNA had heard a noise and found (R2) lying on the ground. She asked (R2) what had happened and (R2) told her he didn't remember what had happened. (R2) said he was in his bed and then was on the floor. We performed a video visit which didn't order an ER (emergency room ) visit. However, due to facility policy and (R2) receiving blood thinners, he was sent to the local ER.<br><br>On 10/03/2024 at 10:55 AM, V5, Care Plan Coordinator stated whenever a resident has a fall, the staff meet together with the department heads and go over all falls and try and figure out the root causes, why the fall occurred, and ways to prevent any future falls. The management staff meet as an Interdisciplinary team, (IDT), regarding the course of action and what interventions to implement for each fall. We then meet again to ensure each intervention is working and no other falls have occurred. For every fall we must have a new intervention.<br><br>On 10/03/2024 at 11:08 AM, V5, stated I was not doing the Care Plans at that time (R2) fell back in August and after I had talked to you I went back and looked at (R2's) Care Plan when I looked back at (R2's) records I realized there were no progressive interventions, and the same intervention was used all three times for his last three falls. It was an error. There should have been a new intervention for each fall, and nothing should have been repeated. This was an error.<br><br>On 10/3/2024 at 11:33 AM, V1, Administrator stated, When we looked back at (R2's) Care Plan we realized we used the same interventions multiple times, and no new interventions were put into place on his falls in August.<br><br>On 10/03/2024 at 12:15 PM, V2, Director of Nursing stated she was new to the position but would expect every fall to have an intervention and not to use the same intervention for multiple falls and have a new intervention for each fall. V2 also stated the care plan should reflect every fall and each intervention should implemented after every fall and assessed to ensure they were working for any future falls.<br><br>The Facility Fall Policy with a revision date of 7/2022 documents, This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All residents' falls shall be reviewed, and the residents' existing plan of care shall be evaluated and modified as needed. |