STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146123	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lacon Rehab and Nursing	401 9th Street Lacon, IL 61540

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. 33973 Based on observation, interview, and record review, the facility failed to ensure safe resident transfer and fall intervention implementation for two (R2 and R3) of three residents reviewed for falls in a sample of five. Findings include: 1. R2's current Physician Order Sheet (POS) documents diagnoses including but not limited to: Lack of Coordination; Unsteadiness on Feet; Unspecified Tear of Unspecified Meniscus, Current Injury, Left and Right; Repeated Falls; Overactive Bladder; and Urge Incontinence. R2's Minimum Data Set/MDS assessment, dated 3/11/24, documents R2 is cognitively intact. R2's Fall Risk Assessments, dated 4/18/24 and 5/20/24, document R2 is a high fall risk. R2's current Care Plan Fall Interventions include but are not limited to Exchange single cord call light for double cord call light for additional access points in room to request assistance. R2's Care Plan also documents R2 has an alteration in her ability to care for self and needs assistance due to cognitive impairment, decreased strength and endurance, weakness. Interventions include R2 requires total dependence on one to two staff for toilet use. On 6/6/24, at 11:45am, R2 sat in a wheelchair in her room with a single cord call light clipped to her recliner. There is no double cord call light in R2's room. At this time, V15 Licensed Practical Nurse/LPN confirmed there is only a single cord call light in R2's room and stated She used to have one. She was recently moved to this room. It is a cord that splits at the end, and she used to have one so there was one on her bed and one on her recliner. Now she has to rely on staff to move it which we should be doing anyway. Prior to checking R2's room for the double cord call light, V15 reviewed R2's Care Plan and confirmed that R2 is supposed to have a double cord call light. R2's Nurse Progress Note, dated 5/19/24 at 9:10am, documents Called to residents' room by CNA (Certified Nursing Assistant) (V16) as resident had slipped when being transferred from WC (wheelchair) to toilet by CNA, (R2) landed on the floor. No gait belt applied by CNA prior to transfer and per resident not attempted to place on her. Resident was sitting on buttocks on shower ledge and had hit her left side of back on ledge of shower. (continued on next page)

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	R2's Nurse Progress Note, dated 5/19/24 at 10:26am Spoke with resident once settled in her recliner after falling in bathroom and resident informed need to always wear her gait belt. 'He didn't put it on me, I didn't refuse.' Discussed to not allow anyone to transfer her unless she has a gait belt on and to call the nurse if anyone attempts to do so. Resident agreed to use gait belt and call nurse if any issues. The facility's fall investigation titled Witnessed Fall w/o (without) Injury for R2, dated 5/19/24, documents Incident Description: Resident being transferred from wheelchair to toilet by CNA (Certified Nursing Assistant) without gait belt and resident fell back hitting left side of back or shower ridge from floor. Per CNA and resident did not hit head. Nursing Description: I slipped while being transferred to toilet and hit my left side of back on shower floor. Immediate Action Taken: Description includes Vitals started once resident completed toileting and discussion with resident about need to always use gait belt when transferring and to remind staff if they don't place one on her. Stated 'he didn't put it on me.' This investigation also states Notes: Staff educated on using gait belt when transferring resident as resident allows. On 6/6/24, at 10:30am, V16 CNA stated I answered her (R2's) call light and when I went to go put the gait belt on (R2) she refused the gait belt like in the past. (R2) said no, so I said OKAY and took her into the bathroom. I was transferring and guiding her, and she fell . After she fell , I automatically went and got the nurse. She had no injuries. I should have demanded that (R2) let me put the gait belt on. The facility's Record of Interview Corrective Action, dated 5/21/24, documents V16 CNA was issued an oral warning Education on gait belt transfers. On 6/6/24, at 10:40am, R2 is sitting in a wheelchair in the dining room. R2 stated that she has never refused to let staff put a gait belt on her. When referring to her fall on 5/19/24 in her bathroom R2 stated He must have thought I was strong enough without one. On 6/6/24, at 12:10pm, V3 Assistant Director of Nursing/ADON stated that if a resident refuses to let staff put a gait belt on for transfer, they are to educate then report it right away to the nurse. They are not to transfer them without one but are to go tell the nurse. The nurse will then educate the resident. The residents here are compliant with gait belts. 2. On 6/4/24, at 12:53pm, R3 was in her room standing in front of her recliner without any non-skid strips on the floor under where she stood. R3's current POS documents diagnoses including but not limited to Unspecified Lack of Coordination; Unspecified Abnormalities of Gait and Mobility; and Muscle Weakness, generalized. R3's Minimum Data Set/MDS assessment, dated 3/7/24, documents R3 is cognitively intact. R3's Fall Assessments, dated 2/20/24 and 4/18/24, document R3 is a high fall risk. R3's current Care Plan documents Fall Interventions including but not limited to Non-skid strips in front of recliner. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/24, at 9:54am, V15 Licensed Practical Nurse/LPN entered R3's room and verified there are no non-skid strips on the floor in front of R3's recliner. V15 is unsure at this time if R3 is supposed to have them. V15 then looked up R3's Care Plan and stated that according to R3's Care Plan R3 should have the non-skid strips on the floor in front of her recliner. V15 reviewed some of R3's falls and stated, That makes perfect sense. On 6/6/24, at 10:00am, R3 was standing up in her room in front of the recliner folding a blanket with her walker off to the side. R3 was leaning forward and wobbly. There were no non-skid strips under her feet on the floor. R3 stated R3 has seen those strips all over the building, but not in front of her recliner. The facility's Fall Reduction Policy, revised 6/17/22, documents Purpose: To provide an environment that remains as free of accident hazards as possible. To identify residents who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent or minimize fall related injuries. To promote a systematic approach and monitoring process for the care of residents who have fallen and/or those who are determined to be at risk. The facility's Gait Belt Transfer policy, revised 11/5/19, documents Purpose: To transfer or ambulate an individual with lower extremity weakness safely.