STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146177	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resthave Home-Whiteside County	408 Maple Avenue Morrison, IL 61270

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543 Based on observation, interview, and record review the facility failed to immediately notify a resident's Power of Attorney (POA) after the resident experienced a fall and a skin tear. This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 5. The findings include: R1's Admission Record (Face Sheet) showed an admitted [DATE] with diagnoses to include but not limited to partial paralysis following a stroke; cognitive communication deficits; and mobility abnormalities. R1's 1/22/25 Minimum Data Set (MDS) showed she had moderate cognitive impairment. R1's Incident Note from 2/20/25 at 1:36 PM showed, Resident found lying on floor between bed and [fall mat]. Small skin tear noted to left elbow. Resident able to move all extremities. Fax sent to [R1's Primary [NAME] Physician]. POA to be notified in AM. Vital signs stable. R1's Order Note from 2/20/25 at 10:06 AM, showed Resident c/o (complains of) pain in right shoulder and right elbow. Bruising noted on right elbow. Resident had a fall out of bed last night. Resident stated 'My arm hurts so bad, its broken' repeatedly this morning. Resident was able to move that arm and squeeze this nurse's hand .POA notified and agreed to order . (An X-ray was ordered and no injuries were identified.) R1's Unwitnessed Fall incident report from 2/20/25 at 1:00 AM showed only R1's physician was notified. On 2/25/25 at 11:00 AM, R1 was at the nurses' station in her wheelchair. R1 had a 1 inch by 1/8-inch wound to her left elbow that was open to air. R1 also had significant bruising to her right forearm. R1 was pleasantly confused and talkative. On 2/25/25 at 9:25 AM, V4 R1's (POA) stated, while reviewing his call log, he was not notified of R1's fall until 9:46 AM on 2/20/25. V4 stated R1 has had numerous falls and the facility routinely notifies him late after these falls. V4 stated he expects to be notified day or night when R1 falls, especially when she has an injury like a skin tear. V4 said he expects to be notified so he can make better informed and more timely decisions regarding R1's care. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 2:18 PM, V2 Director of Nursing (DON) stated if a fall occurs during the night the third shift nurse is supposed to notify the family at the end of their shift (6:00 AM). V2 stated this policy has been in place prior to her being the DON and the nurse on duty the morning of 2/20/25 was well aware of this policy. V2 said the purpose of notifying the family of falls is so they are kept informed of resident changes and so they can make better decisions regarding resident care. The facility's Family/Responsible Party Notification of Resident Change of Condition policy (effective 2/10/12) showed notification for change in condition does not need to be made until 10:00 AM if the event occurred during the night. The facility's Fall Management Policy (Rev 2/13/19) showed no mention of family notification.

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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 - 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** 39543 Based on observation, interview, and record review the facility failed to ensure a resident with history of falls was assessed after a reported fall. The facility also failed to ensure staff were aware of a residents fall history and fall interventions in place for R1. The facility failed to implement appropriate fall interventions, and failed to ensure fall interventions were implemented correctly. This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 5. The findings include: R1's Admission Record (Face Sheet) showed an admitted [DATE] with diagnoses to include but not limited to partial paralysis following a stroke; cognitive communication deficits; and mobility abnormalities. On 2/25/25 at 11:00 AM, R1 was at the nurses' station in her wheelchair. R1 had a 1 inch by 1/8-inch wound to her left elbow that was open to air. R1 also had significant bruising to her right forearm. R1 appeared confused but was talkative. The facility's Fall/Incident log, provided on 2/25/25 at 9:00 AM, showed R1 had falls on 1) 1/21/25 at 7:30 AM 2) 2/13/25 at 12:00 AM (Midnight) 3) 2/20/25 at 1:00 AM. The fall log showed all three falls were Roll out of bed. The log showed no documented fall on 2/16/25. R1's Incident Note showed a fourth potential fall on 2/24/25 at 3:28 PM. The note showed she rolled out of bed onto her fall mat and was complaining of left sided abdominal pain and she had bruising to that area. The incident note showed V4 R1's Power of Attorney (POA/Family) was notified, and he was alarmed at the number of times R1 was climbing out of bed and being found out of bed. On 2/25/25 at 9:25 AM, V4 stated he arrived at the facility on 2/16/25 at approximately 4:00 PM. V4 stated he heard (R1) calling out as he entered her room. V4 stated R1 was between her bed and the fall mat on the floor. V4 stated he and V5 (V4's Family) transferred R1 back to bed. V4 stated the facility did not have adequate interventions in place to prevent R1's fall such as a bed alarm. On 2/25/25 at 10:07 AM, V5 stated she was with V4 at the facility 2/16/25 around 4:00 PM. V5 stated as they rounded the corner for R1's hallway, V5 could hear R1 calling for help. V5 stated as they entered R1's room (R1) was on the floor between the fall mat and the bed. V5 stated R1 was complaining of right arm and right shoulder pain. V5 stated herself and V4 transferred R1 off the floor to the bed. V5 stated V3 Registered Nurse (RN) and V8 Certified Nursing Assistant (CNA) were in the room during the transfer and were aware of the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 1:38 PM, V8 (CNA) stated he worked 3:00 PM to 3:00 AM beginning on Sunday 2/16/25. V8 stated he only works Saturday, Sunday, and Monday. V8 stated he recalled 2/16/25 and stated R1 was out of bed on the fall mat. V8 stated another CNA told him R1 was on the floor or fall mat. V8 stated when he went in the room the family had transferred R1 back to bed. V8 stated he notified V3 that R1 had fallen and the family was upset. V8 stated he assumed R1 had a previous fall based on a scab on her forehead; however, he was not for certain how often she had fallen or her tendencies for falling. V8 stated he should be aware of residents that are a fall risk and how they typically fall so he can better monitor residents for those tendencies. V8 stated he would get this information in report. V8 stated he was not given this information in report. V8 said interventions for residents who fall frequently would be to leave the door open, frequent rounding, and keeping the resident at the nurses' station when they are awake. V8 said he only works weekends and there are many things that happened during the week that he is not aware of. On 2/25/25 at 2:00 PM, V9 (CNA) stated she was also assigned to R1 on 2/16/25 at 4:00 PM. V9 stated she had heard R1 had fallen out of bed. V9 stated she assumed R1 had a history of falls due to the scab on her forehead; however, she was not aware how R1's falls had occurred. V9 said, Prior to this I was not aware of how she had fallen. I was not aware her falls were out of bed on 2/13/25 and 1/21/25. She probably should have had an alarm (bed alarm) on 2/16/25. There should be a mechanism in place for us CNAs to be made aware of how residents have fallen [in the past]. V9 stated interventions for frequent falling residents would be to keep the door open, frequent rounding, and keeping the resident at the nurses' station. V9 said she did not know if these interventions were in place for R1. V9 said R1 was in a skilled nursing bed, and she does not think of those residents as being high fall risk residents. On 2/25/25 at 11:35 AM, V3 (RN) stated she recalls working on 2/16/25 and stated she recalled V4 being upset. V3 stated she was not aware R1 fell , or she was on the fall mat on 2/16/25. V3 said if there was a fall she would have documented it and assessed R1. R1's Nursing Note from 2/16/25 at 5:00 PM, showed Family concerned about patient and type of rails on bed. Patient is able to maneuver out of bed to large bean bag. Family is requesting tabs alarm for safety. Family voiced their concerns with nurse and requested to visit with Social Worker and Administrator. Attempted to explain alternatives to mattress and potential closer room to nurses station. (The note does not mention a reported fall.) On 2/25/25 at 2:18 PM, V2 (Director of Nursing) stated, following a fall, residents should have a head-to-toe assessment and the fall should be documented in the medical record. V2 stated she was not aware R1 had a reported fall on 2/16/25. V2 said it is the nurses' responsibility to determine if a fall occurred. V2 said a fall is defined as a person going from one plane to a lower plane. V2 said if V3 was not able to observe R1's position due to family putting her back to bed, V3 should have taken the most conservative route and treated the incident as a fall. V2 said V3 should have assessed R1 for injuries and documented the incident. V2 said the purpose of the assessment is to determine if there is an injury, which may require intervention. V2 said CNAs should be aware of residents who fall frequently, and the CNAs should be aware of the residents' common tendencies for falls. V2 said this information would be important for the CNAs so they could monitor for these tendencies and possibly prevent falls. V2 said typical interventions for frequent falling residents would be to leave the door open, frequent rounding, and keeping the residents with staff when awake. V2 said staff should have also been using pillows around R1 for positioning and to assist in keeping her in bed. V2 said these interventions should be in R1's care plan and staff should be aware. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's fall risk care plan lacked the following interventions: keeping her out of her room when awake, leaving her door open, frequent fall monitoring rounds, and using pillows for positioning. R1's 2/20/25 Incident Note from 1:36 AM showed, Resident found lying on floor between bed and [an oversized mattress resembling a square bean bag, used by facility as a plush fall mat for R1]. Small skin tear noted to left elbow. Resident able to move all extremities . On 2/26/25 at 8:45 AM, V2 stated if R1's fall mat was used correctly, the resident should not fall between the mat and the bed and be on the floor. V2 said R1's large fall mat should be tucked in under R1's mattress to prevent this from happening. (V3 and V4's statements also show R1 was on the floor, between the square bean bag/plush fall mat and her mattress, on 2/16/25.) The facility's Fall Management policy (revision 2/13/19) showed, If a fall occurs the Charge Nurse completes an incident report and assesses the resident's condition. The policy showed continued fall monitoring will continue for 48 hours. The policy showed the Director of Nursing and other administration staff will review the incident report and determine the root cause of the fall. The policy showed staff will then develop and implement fall interventions .in an effort to prevent recurrences.