STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Health Care Center	#5 Doctors Park Mount Vernon, IL 62864

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 - 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. 39744 Based on interview and record review the facility failed to notify a resident's physician for a fall with injury in a timely manner for one of three residents (R1) reviewed for falls in a sample of 7. This failure resulted in delayed treatment for R1's impacted distal radius fracture and ulnar styloid fracture of the right wrist. Findings included: According to R1's Admission Face Sheet and Cumulative Diagnosis sheet, R1 was admitted to this facility on 12/7/2022 with the diagnoses of Severe Dementia associated with Alcoholism without behavioral Disturbance, Psychotic Mood Disorder, and Anxiety. R1's MDS (Minimum Data Set) dated 12/18/2023, documented an attempt to assess R1 using the BIMS (Brief Interview for Mental Status) test, but R1 was unable to perform the test due to rarely or never understood and thus had no score out of 15 total indicating R1 has severe cognitive impairment. This same MDS documented R1 is independent with walking, transferring, does not use a wheel chair and has no impairment to upper and lower extremities. On 4/11/2024 at 9:22am, V6 (Certified Nursing Assistant/CNA) said on 3/31/2024 she was working R1's unit the evening R1 fell out of bed. V6 said at around 10:00pm, she was up at the nurses station, which is close to R1's room, when she heard a loud thump and went to check on R1. V6 said she found R1 sitting on the floor next to her bed. V6 said R1 told her she was ok so she helped R1 back into bed and went to report the fall to the nurse (V5) and V5 came to see R1 immediately. On 4/11/2024 at 8:45am, V5 (Licensed Practical Nurse/LPN) said on 3/31/2024, she and V6 were working on R1's hallway when R1 fell out of bed and hurt her right wrist. V5 said she assessed R1 and did not find any injuries to R1's body except R1's right hand/wrist was very bruised and swollen. V5 said she contacted R1's family to report the fall and injury. V5 said she tried to contact R1's doctor all night, but did not get an answer. V5 said she did not send R1 to the local emergency room and thought the next shift (day shift) would notify the doctor of R1's fall and injury to right wrist/hand and get treatment for R1. (continued on next page)

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

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On 4/11/2024 at 11:26am, V11 (LPN) said she worked the dayshift on 4/1/2024 and 4/2/2024 but did not remember being told in report about R1's fall and right wrist/hand injury, bruising and swelling and thus did not continue to attempt to notify R1's doctor on either day. V11 said it is so hectic and loud on the dementia unit that she has trouble concentrating. V11 said the facility was not short staffed and she feels adequately trained, but has only worked at this facility for about 3 months. V11 said on the morning of 4/1/2024, R1 came to her and showed her the injured wrist, but V11 did not catch what R1 was trying to tell her. V11 said on 4/2/2024 at 12:00pm, during the noon meal, V18 (Social Service Director) was the first staff to notice R1's right hand was injured and asked V2 (Director of Nursing/DON) to take a look at it. V11 said she was too busy to contact R1's doctor until around 3:00pm when she sat down to chart at the nurse's station. V11 said at 3:00pm, she notified V14 (Nurse Practitioner) of R1's right wrist/hand injury with swelling and bruising. A Social Service Progress Note in R1's medical record dated 4/1/2024 documented by (V18/Social Service Director/SSD) the following: Was told in morning meeting the resident (R1) had fallen out of bed. After morning meeting I sat down with resident in her room. She claims it doesn't hurt Not really is what she said. Couldn't explain what happened to me. Only said It just happened yah know. A Nurse's Note in R1's medical record and dated 4/1/2024 (actual date of entry 3/31/2024) documented V5 called R1's doctor at 10:45pm, 11:20pm and on 4/1/2024 at 4:15am, but the doctor's phone continued to have a busy signal every time V5 called. A Social Service Progress Note in R1's medical record dated 4/2/2024 by (V18/Social Service Director/SSD) documented the following: Writer noticed residents (R1) Rt (right) arm bruised, hand/palm swollen. I (V18) reported this to DON (Director of Nursing-V2). She immediately when (sic) down to resident's room. Xray was ordered (mobile x-ray service name). After results was taken to ER (emergency room) Returned with temp (temporary) cast . A Nurse's Note in R1's medical record entered by V2 (DON) on 4/2/2024 at 12:40pm documented the following: Request from SS (Social Services) to check residents R (right) arm, has bruising and R (right) hand palm is swollen. Resident c/o (complained of) pain when hand touched, but could not rate pain. Will contact NP (Nurse Practitioner). A Nurse's Note in R1's medical record entered by V2 on 4/2/2024 at 1430 (2:30pm) documented the following: Clarification of R (right) forearm discoloration. Dark bruising vertical marks with yellow discoloration around the wrist area. Palm of the hand is discolored also (dark). (R1) has no recall of hurting her arm. A Nurse's Note in R1's medical record by V11 (LPN) on 4/2/2024 at 3:00pm documented the following: Resident noted to have bruising at different stages to the R (right) wrist and to R (right) forearm. Notified mother who states res. (resident) has had a cast in the past and will not leave it alone, that she will work it off. Notified provider (V14 /Nurse Practitioner) via (name of messaging service used to communicate with providers) with pictures . A Nurse's Note in R1's medical record by V11 (LPN) on 4/2/2024 at 6:30pm documented the following: (mobile x-ray service providers name) personnel here (at facility) to do x-ray to R (right) forearm. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	The x-ray service provider results for R1 dated 4/2/2024 documented the following: Procedure-Right Forearm, 2 views, Findings-an impacted distal radial fracture is identified. The fracture does not involve the articular surface. An ulnar styloid process fracture is also noted. Moderate degenerative changes are present. The remaining osseous structures are intact. R1's ED (Emergency Department) Physician Documentation from the local hospital dated 4/3/2024 documented the following in part: This patient presents from the nursing home with diagnosis of an impacted distal radius fracture and ulnar styloid fracture of the right wrist. This was sustained in a fall yesterday. A Nurse's Note in R1's medical record by V5 (LPN) on 4/3/2024 at 4:40am documented the following: Rec'd (received) stat x-ray results #1 R (right) wrist fx (fracture), #2 R (right) forearm fx (fracture), #3 R (right) hand fx (fracture). A Nurse's Note in R1's medical record by V5 (LPN) on 4/3/2024 at 4:45am documented the following: Called (name of on call doctor) TO (telephone order) to send resident (R1) to ER (emergency room) for eval (evaluation) and Tx (treatment). On 4/11/2024 at 12:39pm, V2 (Director of Nursing/DON) and V3 (Assistant DON) were interviewed at the same time and both agreed R1's doctor was not notified of R1's injuries and fall in a timely manner and that it should not have taken 2 days to begin providing R1 care of her injured right wrist/hand that was determined 2 days later to be a fractured right wrist. V3 said when R1's doctor could not be reached, V5 (LPN) should have sent R1 to the local emergency room for evaluation of her right wrist/hand injury at the time the injury was first discovered. V2 said V11 (LPN) should have continued to reach R1's doctor but failed to do so. V2 said the facility does not have a policy on what the nursing staff should do if they cannot reach the resident's doctor in a timely manner, but they will look into getting one.

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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. 39744 Based on interview, record review, and observation the facility failed to implement fall interventions to prevent future falls after a fall with injury occurred for one of three residents (R1) reviewed for falls in a sample of seven. Findings included: According to R1's Admission Face Sheet and Cumulative Diagnosis sheet, R1 was admitted to this facility on 12/7/2022 with the diagnoses of Severe Dementia associated with Alcoholism without behavioral Disturbance, Psychotic Mood Disorder, and Anxiety. R1's MDS (Minimum Data Set) dated 12/18/2023, documented an attempt to assess R1 using the BIMS (Brief Interview for Mental Status) test, but R1 was unable to perform the test due to rarely or never understood and thus had no score out of 15 total indicating R1 has severe cognitive impairment. This same MDS documented R1 is independent with walking, transferring, does not use a wheel chair and has no impairment to upper and lower extremities. A Fall Risk Assessment in R1's medical record dated 4/1/2024 documented R1 is a high risk for falls. No other fall assessments for R1 could be reproduced by the facility when asked during this survey. On 4/11/2024 at 9:22am, V6 (Certified Nursing Assistant/CNA) said on 3/31/2024 she was working R1's unit the evening R1 fell out of bed. V6 said at around 10:00pm, she was up at the nurses station, which is close to R1's room, when she heard a loud thump and went to check on R1. V6 said she found R1 sitting on the floor next to her bed. V6 said R1 told her she was ok so she helped R1 back into bed and went to report the fall to the nurse (V5) and V5 came to see R1 immediately. On 4/11/2024 at 8:45am, V5 (Licensed Practical Nurse/LPN) said on 3/31/2024, she and V6 were working on R1's hallway when R1 fell out of bed and hurt her right wrist. V5 said she assessed R1 and did not find any injuries to R1's body except R1's right hand/wrist was very bruised and swollen. V5 said she contacted R1's family to report the fall and injury. A Social Service Progress Note in R1's medical record dated 4/1/2024 documented by (V18/Social Service Director/SSD) the following: Was told in morning meeting the resident (R1) had fallen out of bed. After morning meeting I sat down with resident in her room. She claims it doesn't hurt Not really is what she said. Couldn't explain what happened to me. Only said It just happened yah know. The x-ray service provider results for R1 dated 4/2/2024 documented the following: Procedure-Right Forearm, 2 views, Findings-an impacted distal radial fracture is identified. The fracture does not involve the articular surface. An ulnar styloid process fracture is also noted. Moderate degenerative changes are present. The remaining osseous structures are intact. (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 ED (Emergency Department) Physician Documentation from the local hospital dated 4/3/2024 documented the following in part: This patient presents from the nursing home with diagnosis of an impacted distal radius fracture and ulnar styloid fracture of the right wrist. This was sustained in a fall yesterday. A Final Investigation Report received by the (State Agency) dated 4/8/24 documents the following in part: This serves as the final follow up report to the initial report of an alleged incident with injury involving (R1) sent on 4/3/24 . In conclusion, the facility can substantiate an injury occurred when (R1) was lying close to the edge of her bed and fell . She has a follow up appointment with orthopedic services on 04/16/2024. QA (Quality Assurance) team met and reviewed care plan and determined the cause of the fall to be (R1's) poor safety awareness related to her dementia diagnosis. She has been placed on 15 minute visual checks, staff will encourage resident to change to a safe bed position and a floor mat will be placed at bedside when resident in bed. SSD (Social Service Director) will continue to meet weekly with (R1) to allow time to discuss feelings and concerns. Care plan has been updated to reflect current status. (R1) remains at baseline. On 4/10/2024 at 9:20am, no fall mat was seen in R1's bedroom, which is on the dementia unit. On 4/11/2024 at 2:30pm, no fall mat was seen in R1's bedroom. On 4/17/2024 at 8:12am, no fall mat was seen in R1's bedroom. On 4/17/2024 at 7:58am, V15 (CNA) said none of the residents on the dementia unit uses a fall mat during the day or during the night. On 4/17/2024 at 8:01am, V16 (CNA) said no one on the dementia unit uses a fall mat during the day or during the night. On 4/17/2024 at 8:48am, V4 (LPN) said R1 resides on the dementia unit. V4 said none of the residents on the dementia unit, including R1, use a fall mat as a fall intervention. R1's Care Plan is noted to be 5 pages long with a start date of 1/30/2024. R1's care plan included the following focus areas: Cognitive Loss/Dementia, Communication, ADL (Activities of Daily Living) Function Rehab, Continence, Activities, Nutrition, Pressure Ulcers, Return to Community and Life Style Preferences. This same Care Plan does not include a plan of care for R1's fall with injury, which occurred on 3/31/2024 and does not include interventions to prevent future falls for R1. The facility Fall Prevention Policy dated 11/28/2012 documents the following in part: Purpose: To assure the safety of all residents in the facility. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions, to provide necessary supervision and assistive devices are utilized as necessary. Safety interventions will be implemented for each resident identified at risk. All assigned nursing personnel are responsible for ensuring on-going precautions are put in place and consistently maintained. Fall risk interventions will be identified on the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/11/2024 at 12:39pm, V1 (Administrator), V2 (Director of Nursing/DON) and V3 (Assistant DON) were interviewed at the same time. V1 said R1 is supposed to be using a fall mat, but the facility does not have one for her and needs to get one ordered. V1 said R1 has not had a fall mat in place as indicated in the final report sent to (State Agency) on 4/8/2024 and R1's care plan was not updated. V2 said R1's care plan should have included a focus area for falls with fall interventions created to prevent R1 from future falls, but they failed to update R1's care plan after R1 fell .