STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510288	A. BUILDING: _____ B. WING _____	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS MEMORY CARE - CHATHAM	401 N PARK AVENUE CHATHAM, IL 62629

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A 000	Initial Comment Complaint Investigation Complaint 2446762/IL177154 Complaint can be substantiated.	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Based on record review, interview, and camera footage, the establishment failed to ensure R1 remained free from neglect. R1 fell from a recliner on 07-27-2024 shortly after 3:00am and staff did not come to assist R1 until shortly after 6:00am. R1's health declined over the next few days and R1 expired on 08-05-2024. Findings include: Z1, complainant, was interviewed on 8-28-2024 approximately 8:30am. Z1 states that R1 fell from a chair and lay on the floor from three hours before he was found and that a female staff person drug R1 from the floor to R1's bed. Z1	A6000		

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A6000	Continued From page 1	A6000		

states that R1 couldn't stand and that someone else came into the room to help put R1 into the bed. Z1 states the establishment is to check on R1 every two hours. Z1 further states that they have a camera in R1's room, and that the staff took R1 into the bathroom. Z1 states that R1 was not able to stand or walk again after the fall. Z1 states that you can hear R1 stating "no" when staff were trying to get R1 up to the bed. Z1 states R1 went downhill really fast after the fall, that R1 wasn't sent to the hospital because R1 was a DNR, (do not resusitate.) Z1 also states that the coroner told her the death was due to a stroke.

Received three photos from Z1, which were viewed. The first picture shows R1 lying on floor on left side in front of recliner/chair with a walker appearing few feet away up against the wall; appears resident's pants are down around knees; door to the room is closed. The second picture appears to be a female staff lifting R1 under R1's arms from behind R1; both R1 and staff person are maybe a few feet away from chair and closer to the foot of R1's bed; R1's legs are off to the right of his trunk with feet on the floor and walker appears to be in same spot against the wall; the door to R1's room is propped open with bedding. The third picture appears to be R1 sitting on buttocks on the floor with R1's legs in front of R1, the walker is now in front of R1 and over R1's legs, R1's back is leaning against staff person's legs; staff person looking towards door and another female staff person is walking through R1's doorway; the door to the hallway is still propped open with bedding.

On 08-29-2024, approximately 1:50pm, E1, (Executive Director,) and E2, (Wellness Director,) both stated that R1 did have a camera in R1's

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A6000	Continued From page 2	A6000		

room and that there was signage regarding the camera outside of R1's door. E1 states that they check on every resident in the building every two hours and that following R1's 07-27-2024 fall, that R1 was checked on every hour.

R1 was admitted to the establishment on 08-04-2022. R1's diagnoses include dementia, dysphasia following nontraumatic intracerebral hemorrhage, seizures, and type 2 diabetes mellitus.

R1's 08-08-2023 service plan contains documentation that R1 requires extensive assistance with personal hygiene, is independent with ambulation using a walker, is independent with transfers, requires assistance using the bathroom, and that R1 is at risk for falls. The service plan includes documentation of fall interventions initiated on 08-08-2023 that are: avoid over stimulating R1 in the evening time, to provide quiet activities, ensure a night light is on in the apartment during the night, do not attempt to use reality orientation with R1, attempt redirection when R1 is anxious or frustrated, to speak slowly when assisting R1, and to explain the process to R1 priorto starting care.

R1's 08-08-2023 Fall Risk Evaluation contains documentation that R1 is at moderate risk for falling.

R1's 07-27-2024, 6:01am, Unwitnessed Incident without Injury report contains documentation that the caregiver called the nurse for assistance with R1. Documentation includes that when E3 approached R1's room, that the caregiver was standing behind R1 while R1 was sitting on the floor; and that the caregiver stated the resident had sat on the floor due to not wanting to walk to

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A6000	Continued From page 3 the restroom. Documentation includes that the nurse assisted the caregiver with getting R1 into the restroom where the caregiver dressed R1 and R1 was assessed. Further documentation is that R1 was assisted to R1's recliner and that emergency services are not needed at this time, and that no injuries were noted at the time of the incident. The form also includes documentation that R1 is "stuporus, responsive only to vigourous stimulation." R1's 07-27-2024, 6:12am, progress note contains documentation that R1 was refusing to walk and that E3, (Licensed Practical Nurse,) assisted the caregiver with getting R1 into the restroom. Further documentation is that the caregiver dressed R1 while E3 assessed R1. R1 was then assisted back to the recliner. Emergency services were not needed at this time and that E3 reported the incident to the oncoming nurse. Night safety checks will continue every two hours. R1's 07-27-2024, 8:32am, progress note contains documentation that R1 was discovered on the floor at 6:15am, that the caregiver stated R1 sat on the floor refusing to use the restroom. Further documentation is that the nurse came to assist getting R1 off the floor, that R1's clothing was changed, and that R1 was assisted back to a recliner. Documentation includes that no injuries were noted and that R1's power of attorney was notified of the incident. The power of attorney stated that she was watching her camera in R1's room and that R1 had fallen, not sat down. Documentation includes that the power of attorney did not want R1 sent out for emergency services, that the power of attorney is in the establishment during the day with R1, and that the power of attorney didn't mention that R1 was experiencing any problems or difficulties.	A6000		

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A6000	Continued From page 4 R1's 07-27-2024, 7:37pm progress note contains documentation that R1's family is aware of the incident and that one daughter states R1 was rubbing the left hip, and that the power of attorney probably would not want R1 sent out to the emergency room. R1's 07-30-2024, 9:55am, progress note contains documentation that R1's power of attorney refused to sign the refusal of treatment form. R1's 08-01-2024 , 6:35pm, progress note contains documentation that R1's condition has declined in the last several days, that R1 has not had any medication, fluids, or food. And that R1 does open eyes with staff's voices, but is not verbal when awake. Further documentation is that R1's family is at the bedside. R1's 08-02-2024, 12:38pm, progress note contains documentation that R1's power of attorney told E1 that R1 is declining and that she called for a hospice consult. The power of attorney told E1 that the hospice company would be at establishment on 08-03-2024 to do the resident consultation. R1's 08-03-23-2024, 9:35am, progress note contains documentation that R1 is admitted to the hospice program, that R1 is currently non-verbal and noted to have rapid respirations at 40 and a pulse of 136. Further documentation is that R1 has been noted to be "audibly congested." R1's 08-05-2024, 4:12am, progress note contains documentation that R1 does not have any respirations at this time, that the hospice nurse was notified and came to establishment to pronouce resident deceased, and that family is at	A6000		

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A6000	Continued From page 5 the bedside. On 08-28-2024, approximately 2:15pm, E1 states that the staff in the third picture are E3 and E4, (caregiver.) E1 states that E4 did not return to work after that incident and no longer works at the facility. E4's 08-28-2024, written statement contains documentation that on 07-27-2024 at about 6:30am, the caregiver (E4) called for assistance and that as she entered R1's room that E4 was standing behind R1 with her knees to R1's back while R1 was sitting up on the floor with the walker in front of R1. Further documentation is that E4 stated that R1 sat on the floor when she was assisting R1 to the bathroom and that she needed help standing R1 up. Documentation includes that E4 helped assist R1 up and to the restroom, that E4 changed R1's clothing and that no bruises or injuries were noted at this time. Documentation also includes that E3 helped E4 assist R1 to the recliner. Videos were received from Z2 on 08-28-2024 during the evening hours. The first video shows R1 moving around in the chair as if trying to get up from chair. It is dated 07-27-2024 shortly after 3:00am. The second video shows R1 on the floor and E4 walking into the room asking resident what happened; dated 07-24-2024 shortly after 6am. The third video shows E4 sitting R1 up on the floor and attempting to move R1 by placing her hands under R1's arms while standing behind R1. E4 is seen lifting R1 and moving R1 almost in a 180 degree half-circle, closer to the foot of the bed, then placing R1's walker over R1's legs in front of R1. R1's back is leaning against E4 legs and E4 is seen calling from help.	A6000		

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A6000	Continued From page 6 Z2 was asked if video of R1 falling from the recliner could be sent and she replied via email that the camera missed the actual fall and that she sent all footage available from that night.	A6000		