STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510503	A. BUILDING: _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMOINE RETIREMENT LIVING	203 N RANDOLPH STREET MACOMB, IL 61455

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A 000	Initial Comment Original complaint investigation #2428416/IL179404	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Section 295.4010 Service Plan d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). Type 3 Violation Based on interview and record review, the facility failed to develop and update the service plans with interventions to prevent falls for three of three residents (R1, R2 and R3) reviewed at high risk for falls and failed to include two residents (R1 and R2) out of three reviewed were receiving hospice services. Findings include: 1. R1's face sheet documents he was admitted to the facility on 5-3-24 with diagnoses of Diabetes, Dementia, and Anxiety and is receiving	A4010		

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A4010	Continued From page 1 hospice services. R1's 5-3-24 and 6-6-24 fall risk evaluation documents R1 is at high risk for falls. R1's progress notes/incident reports document the following falls: On 5-24-24 at 5:00 pm, R1 was found on the floor of the dining room under a table. A 3 cm (centimeter hematoma on his left side/back of the head was noted along with emesis. R1 was transported to the hospital with no findings except elevate blood pressure and pneumonia previously diagnosed that morning. On 5-27-24 at 5:00 am, R1's tab alarm sounded R1 was face down on the floor with no injuries noted. On 6-6-24 at 2:48 am, R1 fell toileting himself. No injuries noted. On 6-6-24 at 3:19 pm, a loud noise was heard and R1 was found on the floor on his right side in the dining room. No injuries noted. On 6-7-24 at 8:00 pm, R1 fell face down on the floor. Swollen fingers were noted the next day. On 6-8-24 at 7:25 pm, a thud was heard and R1 found on the floor in the dining room sustaining skin tears to his arms. R1's service plan was not initiated until 6-11-24, over 30 days after his admission and three days after the last fall. Fall intervention include tab alarm, safety checks with rounds, and remind to call for assistance. R1's service plan does not include receiving hospice services. 2. R2's face sheet documents he was admitted on 8-30-22 with diagnoses of Chronic Kidney Disease, Diabetes, Hypertension, and Mild Cognitive Impairment and R2 receiving hospice services. R2's fall risk assessments dated 7-9-24 and	A4010		

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A4010	Continued From page 2 12-14-23 documents R2 is at high risk for falls. R2's progress notes/incidents reports for May, June and July 2024 document the following: On 5-12-24 at 3:30 pm, R2 was found on the floor in his room with pain to his hip. Physical therapy ordered. On 6-2-24 at 4:19 pm, R2 was found on the floor with his head on a folding chair sustaining Bruising to right elbow. On 6-30-24 at 3:30 am, R1 was found on the floor in his room with a head laceration. R2 was sent to the hospital and found to have "multiple brain bleeds" needing nine staples for the laceration and X-rays of his knee. Hospice services started on 6-30-24. On 7-9-24 R2 fell at 5:00 am, was found at 5:20 am on his back with his head resting on the cabinets. R2 sustained a large limp on the right side of his head and an abrasion to his right elbow. On 7-10-24, R2 was found on the floor in his bathroom with a bump to the left side of his head, knee and finger scratches. On 7-12-24 at 10:49 am, R2 was found on the floor with his legs on his walker. R2 complains of pain all over with four skin tears to his arm, an abrasion noted to his right cheek, and redness to his back side of shoulders. On 7-20-24 at 12:25 am, R2 was found to have passed away. R2's service plan dated 7-27-23 does not contain any mention of R2 being at risk for falls nor are there any fall interventions noted. R2's service plan does not include R2 receiving hospice services. 3. R3's face sheet documents she was admitted to the facility on 4-1-23 with diagnoses of Dementia, Hypertension, Diabetes, Anxiety and Congestive Heart Failure and is receiving hospice services.	A4010		

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A4010	Continued From page 3 R3's fall risk assessment dated 4-21-24 documents R3 is at high risk for falls. R3's August, September, and October 2024 progress notes/incident reports document the following falls: On 8-9-24 at 6:55 pm R3 had an unwitnessed fall from her geri chair sustaining skin tears to her right knee and red marks under her right eye. On 9-22-24 at 7:51 am, R3 was found sitting on the floor in front of the elevator sustaining a skin tear to her right elbow. R3's current outdated service plan dated 3-22-24 documents R3 is risk for falls with some interventions. There is no documentation that R3's current falls were evaluated and her service plan reviewed/updated after these falls. The facility's undated fall policy documents "Residents of (facility) who experience a fall, will receive any necessary emergency care, and a review and update of the service plan completed." "an incident report will be completed by the Nurse and reviewed by the Leadership Team within 24 hours." "Ongoing falls will be addressed during a Care conference with the resident, responsible party, and the Leadership Team." On 10-30-24 at 10:30 am, E1 (Executive Director) R2's service plan had not been updated since July 2023 and had no fall interventions documented. E1 verified R1's fall interventions were added only after numerous falls and did not include hospice services. E1 verified R3's service plan was not reviewed/updated after her last listed falls. E1 stated the nurse or DON (Director of Nursing) should be determining what the cause is of the falls and updating the service plan as needed.	A4010		

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A4010	Continued From page 4 .	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: 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; Type 2 Violation Findings include: Based on interview and record review, the facility neglected to provide supervision and interventions to prevent falls for one of three residents (R2) reviewed for falls in a sample of three. R2 fell sustaining multiple brain bleeds, was placed on hospice services and expired. The facility failed to administer pain and anti-anxiety medications to a resident receiving hospice services for one (R2) of three residents reviewed receiving hospice services. Finding include: 1. R2's face sheet documents he was admitted	A6000		

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A6000	Continued From page 5 on 8-30-22 with diagnoses of Chronic Kidney Disease, Diabetes, Hypertension, and Mild Cognitive Impairment. R2's fall risk assessments dated 7-9-24 and 12-14-23 documents R2 is at high risk for falls. R2's progress notes/incidents reports for May, June and July 2024 document the following: On 5-12-24 at 3:30 pm, R2 was found on the floor in his room with pain to his hip requiring X-rays. Physical therapy ordered which R2 declined. On 6-2-24 at 4:19 pm, R2 was found on the floor with his head on a folding chair sustaining bruising to right elbow. R2 was sent to hospital evaluation for bradicardia. On 6-30-24 at 3:30 am, R2 was found on the floor in his room with a head laceration. R2 was sent to the hospital and found to have "multiple brain bleeds" needing nine staples for the laceration and X-rays of his knee. Hospice services were started on 6-30-24. On 7-9-24, R2 fell at 5:00 am, was found at 5:20 am on his back with his head resting on the cabinets. R2 sustained a large lump on the right side of his head and an abrasion to his right elbow. R2's and family refused hospital evaluation. Facility considered moving R2 to the memory care unit for closer observation. On 7-10-24, R2 was found on the floor in his bathroom with a bump to the left side of his head, knee and finger scratches. On 7-12-24 at 10:49 am, R2 was found on the floor with his legs on his walker. R2 complained of pain all over with four skin tears to his arm, an abrasion noted to his right cheek, and redness to his back side of shoulders. Hospice physician notified with no emergency room visit ordered. On 7-13-24, R2 was finally moved to another floor for "closer monitoring." On 7-20-24 at 12:25 am, R2 was found to have passed away.	A6000		

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A6000	Continued From page 6 R2's service plan dated 7-27-23 does not contain any mention of R2 being at risk for falls nor are there any fall interventions noted. The facility's undated fall policy documents "Residents of (facility) who experience a fall, will receive any necessary emergency care, and a review and update of the service plan completed." "An incident report will be completed by the Nurse and reviewed by the Leadership Team within 24 hours." "Ongoing falls will be addressed during a Care conference with the resident, responsible party, and the Leadership Team." On 10-29-24 at 11:10 am, Z1 (Hospice Care Coordinator) stated R2 was on hospice services for a subarachnoid hemorrhage and chronic kidney disease. R2's death certificate dated 7-22-24 documents cause of death as "Subarachnoid Hemorrhage." R2's physician order sheet for July 2024 documents R2 is to receive Morphine Sulfate 5 mg (milligrams) every four hours for pain/end of life care starting 7-13-24 It also documents Lorazepam 0.5 mg every four hours for anxiety/restlessness/end of of life care starting 7-13-24. R2 July 2024 MAR (Medication Administration Record) documents these two medications were not given on 7-14-24 at midnight and 4:00 am and on 7-16-24 at 4:00 am. R2's order dated 7-18-24 documents R2 is to receive Morphine Sulfate 0.6 ml of 20 mg/ml every four hours for pain and Lorazepam 0.5 mg every four hours. R2's July 2024 MAR documents these medications were not given on 7-18-24 at midnight and 4:00 am. R2's order dated 7-18-24 documents R2 is to receive Morphine Sulfate 0.6 ml of 20 mg/ml every six	A6000		

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A6000	Continued From page 7	A6000		

hours for pain and Lorazepam 0.5 mg every six hours. R2's July 2024 MAR documents these medications were not given on 7-19-24 at 2:00 am.

R2 progress note dated 7-14-24 by E9 RN(Registered Nurse) documents "Resident hospice medications are scheduled every four hours. His midnight dose last night and 0400 dose this morning were not able to be administered due to no nurse available."

On 10-29-24 at 11:10 am, Z1 (Hospice Care Coordinator) stated hospice nurses do not administer medications at this facility.

On 10-30-24 at 10:15 am, E8 (LPN/Licensed Practical Nurse) stated when a resident falls, the nurse fills out an incident report. The floor nurses do not determine cause of fall/new interventions. That is for management to do. E8 also stated they do not have night nurses. If a resident requires a medication at night, the on call nurse comes in and gives it. E8 stated R2 was in a lot of pain and needed his medications.

On 10-20-24 at 10:30 am, E1 (Executive Director) stated when a resident falls, the nurse on duty is to fill out an incident report determining the cause of the fall and documenting any new interventions. These are then reviewed by her and the DON/Director of Nursing for accuracy. The DON or nurse will then update the service plan. E1 verified R2 had multiple falls with no interventions placed on the service plan. The facility did attempt therapy for R2, put a camera in his room at one point and provided assistance with activities of daily living but did not develop other interventions, increase supervision or update his service plan.

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A6000	Continued From page 8 E1 verified on call nursing staff were to administer R2's pain/anxiety medications during the night. E1 stated they had problems with a nurse who did not follow thru with giving his medications due during the night. E1 stated there is no nurse on duty at night so they have an on call nurse come in and give any medications needed during the night. E1 stated the former DON was coming in but was not reliable so some of R2's medications were not given. Review of R2's available Incident Reports for the above listed falls does not contain any assessment of the falls or any interventions listed.	A6000		