STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510099	A. BUILDING _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR TRAILS SENIOR LIVING	490 URBANA DRIVE FREEBURG, IL 62243

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Facility Reported Indicent Investigation IL183922 Violation Cited: 295.4010 Service Plans 295.6000 Resident Rights	A 000		
A4010	Section 295.4010 Service Plan This RULE: is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care. c) The service plan shall be signed and dated by all individuals involved in its development. 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	A4010		

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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A4010	Continued From Page 1 in the resident's physical, cognitive, or functional condition (see Section 295.4000). Based on interview and record review the facility failed to ensure individualized fall prevention approaches are developed post fall, and failed to follow facility policy on fall prevention for residents at risk for falls in the facility. This failure creates a substantial probability of harm/injury to residents who are are fall risk. Findings include: R1's Nurses Note dated 12/29/24 documents,"Care Partner (CP) was notified that fall alert was alerting for resident, CP and Nurse found resident on her back with knees bent. Resident could move all extremities. Describe actions and interventions taken: EMS called for lift assist,and assessed resident with no findings, vitals taken, no complaints of pain. Notification: POA, MD, ED, DOW. Follow-up: EMS helped resident into bed she is now resting comfortably. R1's Reportable Report dated 12/30/24 documents, "Incident Time: 0900. Resident fell evening of 12/29, also fell at least once last night, she is using her walker this morning, but very unsteady and complaining of pain to bottom/left hip and not putting weight on right lower extremity. Sent to ER for evaluation. R1's Nurses Note dated 12/30/24 at 1:44 PM documents, "Resident is being discharged, labs, urinalysis, imaging studies, X-rays all done with negative findings. R1's Nurses Note dated 12/31/24	A4010		

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A4010	Continued From Page 2 documents,"Unwitnessed fall 12/31/24 at 6:07 AM. CPs doing hourly checks, found resident on the floor in her room, complained of neck and wrist pain. Describe actions and interventions taken: Placed pillow under head. Took vitals. Called POA and DOW. Transferred to hospital for assessment. Follow-up: Resident at hospital. Referred to skilled nursing facility due to multiple falls within 48 hours. R1's Service Plan prior to falls dated 11/9/24 documents," Low Risk for Falls. R1's Service Plan dated 1/14/25 documents, "Fall Risk Initiated: 8/4/21. Revision 12/7/24. Interventions: Establish toileting routine (date initiated: 12/30/24. Revision on 1/14/25; New Fall 12/31/24. Referred to SNF for Rehab Revision on 12/31/24. Send resident to ER for eval after fall. Date initiated 12/30/24. Date initiated 12/30/24. Revision on 1/14/25. Status checks every two hours. Date initiated 12/29/24. Revision on 1/14/25 Vital signs and weight monitoring related to fall. Date initiated 12/29/24. Revision on 1/14/25. Establish a routine with community. Resident is 1x assist for showers. Date initiated 12/03/24. Revision on 12/30/24. Safety Date Initiated 3/8/24. Interventions: Does not utilize call and safety systems. Foresite camera in place for bed exit alerts and fall alerts." On 1/14/25 at 10:10 AM, E2 (Licensed Practical Nurse) stated all the residents in the Memory Care unit including R1 has a bed exit alarm and fall alert camera as part of the facility safety system that are connected electronically to the work phone that one of the CPs carries on the floor. E2 stated the fall alert camera called a foresight camera alerts staff that a resident has fallen so staff is able to check on the resident who fell immediately and the bed exit pad alarm sends off a notification to the work phone to alert staff that resident is	A4010		

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A4010	Continued From Page 3 trying to get out of bed. On 1/14/25 at 10:28 AM, when asked what interventions she did to prevent future falls for R1, E3/Care Partner/CP stated she checked R1 and other residents who had previous falls every hour and made sure to respond immediately when there is a fall alert from the work phone which one of the CPs carries at work on the unit and every fall alert is announced on the walkie talkies that all care partners have with them to respond and help. E3 stated E1 provided inservice frequently on fall prevention, the latest one she attended was given on 1/2/25. On 1/14/25 at 10:28 AM, E6 (CP) stated she does hourly checks on R1 and responds to the fall alert right away. E6 stated the fall alert alerts staff when a resident falls so someone can check the resident's condition immediately after the fall. On 1/14/25 at 1:40 PM, E1/Executive Director stated the Memory Care unit has Fall management system which includes Foresite cameras installed in resident rooms that sends heat/motion triggered alerts to the work phone when residents are on the floor and bed exit alert pads that sends a notification to the work phone when resident tries to get out of bed. E1 explained that the Foresight cameras sends alerts to her for every fall and she uses the recorded footage to review the falls. E1 was unable to present any post fall incident investigation documentation that may provide causes and predisposing factors contributing to the fall stating the facility has not done any fall incident investigations on resident falls. The Facility Fall Prevention and Management Policy and Procedure updated 12/1/24	A4010		

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A4010	Continued From Page 4 documents,"The Program is intended to reduce the potential for resident falls by enabling staff to identify those residents who are at risk for falling, and then take appropriate control measures. Wellness staff shall collaboratively provide proactive approach to determine causes of falls and finding ways to prevent future falls. Definition: Fall shall be defined as any unintentional change of plane resulting in a resident going from a high to a low or low to high. Responsibilities: Procedure: Community staff should identify fall hazards when noticed in the resident's apartment and to act accordingly to resolve such hazards. Any intervention which is carried out in the best interest of the resident shall be communicated with the resident and responsible party and any additional interventions should be documented. Utilization Review: Any at-risk residents maybe discussed, and a collaborative approach shall be used to determine a plan to prevent future falls to include incident investigation, footwear appropriateness, health and hydration status, etc. Documentation shall be produced noting such a collaboration as well as an update of the resident's status. The Wellness Director, Care Coordinator and interdisciplinary team can then ensure that interventions are followed-through and effective while updating the care plan. Fall Management System. Alerts shall be monitored each work day for the director and coordinator to deem appropriateness for follow-up. Any captured falls shall be reviewed for a cause or predisposing factor. The clips shall also be used to determine effective care and assessment post fall. Care Plans are to be updated with any fall prevention techniques and interventions as a change of condition."	A4010		

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A6000	Continued From Page 5	A6000		
A6000	Section 295.6000 Resident Rights This RULE: is not met as evidenced by: Type 2 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: 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; Based on interview and record review the facility: failed to ensure individualized progressive fall interventions post fall are developed to prevent future falls and failed to follow facility policy on fall prevention and management for residents at risk for falls in the facility. This failure creates a substantial probability of harm/injury to residents. Findings include: R1's Nurses Note dated 12/29/24 documents,"Care Partner (CP) was notified that fall alert was alerting for resident, CP and Nurse found resident on her back with knees bent. Resident could move all extremities. Describe actions and interventions taken: EMS called for lift	A6000		

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A6000	Continued From Page 6 assist,and assessed resident with no findings, vitals taken, no complaints of pain. Notification: POA, MD, ED, DOW. Follow-up: EMS helped resident into bed she is now resting comfortably. R1's Reportable Report dated 12/30/24 documents, "Incident Time: 0900. Resident fell evening of 12/29, also fell at least once last night, she is using her walker this morning, but very unsteady and complaining of pain to bottom/left hip and not putting weight on right lower extremity. Sent to ER for evaluation. R1's Nurses Note dated 12/30/24 at 1:44 PM documents, "Resident is being discharged, labs, urinalysis, imaging studies, X-rays all done with negative findings. R1's Nurses Note dated 12/31/24 documents,"Unwitnessed fall 12/31/24 at 6:07 AM. CPs doing hourly checks, found resident on the floor in her room, complained of neck and wrist pain. Describe actions and interventions taken: Placed pillow under head. Took vitals. Called POA and DOW. Transferred to hospital for assessment. Follow-up: Resident at hospital. Referred to skilled nursing facility due to multiple falls within 48 hours. R1's Service Plan prior to falls dated 11/9/24 documents," Low Risk for Falls. R1's Service Plan dated 1/14/25 documents, "Fall Risk Initiated: 8/4/21. Revision 12/7/24. Interventions: Establish toileting routine (date initiated: 12/30/24. Revision on 1/14/25; New Fall 12/31/24. Referred to SNF for Rehab Revision on 12/31/24. Send resident to ER for eval after fall. Date initiated 12/30/24. Date initiated 12/30/24. Revision on 1/14/25. Status checks every two hours. Date initiated 12/29/24. Revision on 1/14/25 Vital signs and weight monitoring related	A6000		

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A6000	Continued From Page 7 to fall. Date initiated 12/29/24. Revision on 1/14/25. Establish a routine with community. Resident is 1x assist for showers. Date initiated 12/03/24. Revision on 12/30/24. Safety Date Initiated 3/8/24. Interventions: Does not utilize call and safety systems. Foresite camera in place for bed exit alerts and fall alerts." On 1/14/25 at 10:10 AM, E2 (Licensed Practical Nurse) stated all the residents in the Memory Care unit including R1 has a bed exit alarm and fall alert camera as part of the facility safety system that are connected electronically to the work phone that one of the CPs carries on the floor. E2 stated the fall alert camera called a foresight camera alerts staff that a resident has fallen so staff is able to check on the resident who fell immediately and the bed exit pad alarm sends off a notification to the work phone to alert staff that resident is trying to get out of bed. On 1/14/25 at 10:28 AM, when asked what interventions she did to prevent future falls for R1, E3/Care Partner/CP stated she checked R1 and other residents who had previous falls every hour and made sure to respond immediately when there is a fall alert from the work phone which one of the CPs carries at work on the unit and every fall alert is announced on the walkie talkies that all care partners have with them to respond and help. E3 stated E1 provided inservice frequently on fall prevention, the latest one she attended was given on 1/2/25. On 1/14/25 at 10:28 AM, E6 (CP) stated she does hourly checks on R1 and responds to the fall alert right away. E6 stated the fall alert alerts staff when a resident falls so someone can check the resident's condition immediately after the fall. On 1/14/25 at 1:40 PM, E1/Executive Director	A6000		

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A6000	Continued From Page 8 stated the Memory Care unit has Fall management system which includes Foresite cameras installed in resident rooms that sends heat/motion triggered alerts to the work phone when residents are on the floor and bed exit alert pads that sends a notification to the work phone when resident tries to get out of bed. E1 explained that the Foresight cameras sends alerts to her for every fall and she uses the recorded footage to review the falls. E1 was unable to present any post fall incident investigation documentation that may provide causes and predisposing factors contributing to the fall stating the facility has not done any fall incident investigations on resident falls. The Facility Fall Prevention and Management Policy and Procedure updated 12/1/24 documents,"The Program is intended to reduce the potential for resident falls by enabling staff to identify those residents who are at risk for falling, and then take appropriate control measures. Wellness staff shall collaboratively provide proactive approach to determine causes of falls and finding ways to prevent future falls. Definition: Fall shall be defined as any unintentional change of plane resulting in a resident going from a high to a low or low to high. Responsibilities: Procedure: Community staff should identify fall hazards when noticed in the resident's apartment and to act accordingly to resolve such hazards. Any intervention which is carried out in the best interest of the resident shall be communicated with the resident and responsible party and any additional interventions should be documented. Utilization Review: Any at-risk residents maybe discussed, and a collaborative approach shall be used to determine a plan to prevent future falls to include incident investigation, footwear	A6000		

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A6000	Continued From Page 9 appropriateness, health and hydration status, etc. Documentation shall be produced noting such a collaboration as well as an update of the resident's status. The Wellness Director, Care Coordinator and interdisciplinary team can then ensure that interventions are followed-through and effective while updating the care plan. Fall Management System. Alerts shall be monitored each work day for the director and coordinator to deem appropriateness for follow-up. Any captured falls shall be reviewed for a cause or predisposing factor. The clips shall also be used to determine effective care and assessment post fall. Care Plans are to be updated with any fall prevention techniques and interventions as a change of condition."	A6000		