STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SHF520107	A. BUILDING: _____ B. WING _____	C 06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTURY ASSISTED LIVING I	701 SOUTH LEWIS LANE CARBONDALE, IL 62901

(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 Complaint Investigation 2555016/IL193770 Violations Cited: 295.4010a)d)e)g)1)A 295.4040a)4)6)	A 000		
A4010	Section 295.4010 Service Plan This Regulation 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. 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). g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; These requirements were not met as evidence	A4010		

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A4010	Continued From page 1 by: Based on observation, interview and record review, the Establishment failed to ensure the Service Plan identified the level of assistance (R1) required with transfer. This failure resulted in R1 not being properly transferred, causing injury and has have the substantial probability of harm to the other residents residing in the Establishment. Findings Include: R1's Service Plan, dated 10/11/24 documents that R1 utilized a walker, infrequently, or Wheelchair for ambulation, required supervision with transfer. R1's Service Plan also documents the service of an outside Hospice provider. E3/CNA's Witness statement, dated 6/3/25 documents, "On 6/1/2025, 11PM-7 AM I worked building A the morning of 6/2/25. I was assisting (R1) get ready for breakfast, he was changed and dressed in bed, underwear and pants only were changed. Once dressed, I sat him on side of the bed, asked (R1) to stand up, he did not, could not stand alone, I assisted him to stand. I lost footing, I became dizzy and we both fell going to the right. I grabbed him by shirt and stopped him from hitting head on rail, he was half off bed and half on floor. I managed to get up and assist (R1) up to bed sitting on side. rested on chair without problem. While in chair I put long sleeve blue shirt on, wheeled him in front of bathroom to brush hair, then once hair brushed pushed (R1) to table where he remained until I need my shift. I wrote statement about falling and gave it to E4/LPN on the morning of 6/2/25." Upon observation of R1 on 6/5/2025 at 8:40 AM	A4010		

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A4010	Continued From page 2 there are faded bilateral linear bruising noted to the neck approximately 1 inch in length and .5 inch wide. There is a healing skin tear noted to the left upper wrist area near the thumb that is approximately 1 inch linear with scab and minimal bruising. On 6/5/2025 at 9:00 AM, E2/LPN stated R1 had a witnessed fall with staff E3 on the morning of 6/2/25 while assisting R1 with dressing, Staff E3/CNA became dizzy and began to fall, staff grabbed R1's shirt to keep him from hitting the floor with increased force. E2 stated that E3 did not observe any injuries from the incident and reported to a Nurse that AM. The Nurse did do an assessment and there was some old bruising noted from previous falls, hitting his hands on tables, wheelchair etc. E2 stated that the bruise to his neck did not show up until 6/3/2025 when found by Z1/Hospice Nurse. On 6/4/2025 at 3:31 PM. Z3/R1's Son stated that R1 recently went on Hospice care last week for rapid decline both physically and mentally, less mobility and increased sleeping. Z3 stated that R1 recently became wheelchair bound but continues to think he can still walk without assistance.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 2 Violation Section 295.4060 Alzheimer's and Dementia Programs	A4060		

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A4060	Continued From page 3 a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) 4) Provide coordination of communications with each resident, resident's representative, relatives and other persons identified in the resident's service plan; 6) Provide an appropriate number of staff for its resident population. The establishment shall provide staff sufficient in number, with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of the residents and who participate in ongoing training, to serve the resident population. At a minimum, at least one staff member shall be awake and on duty at all times; These requirements were not met as evidence by: Based on observation, interview and record review, the Establishment failed to ensure 1) the residents representative and outside service (Hospice)were notified of a fall, and to communicate the fall with all staff members, 2) failed to ensure staff properly transferred a resident from bed to chair, and 3) failed to monitor and document resident after a fall. (R1) These failures caused injury to R1 and have the substantial probability of harm to the residents residing at the Establishment. Findings include: The Establishment's Incident/Complaint policy, undated, documents, "Any accidents or incidents shall be recorded on the incident accident report. Any incidents requiring medical care shall be	A4060		

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A4060	Continued From page 4	A4060		

reported to IDPH within 24 hours, the resident's doctor and family will also be notified. Any minor incident not resulting in serious injury may or may not be reported to doctor and family depending on the situation."

The Establishment's Fall Prevention Policy, undated, documents, "Purpose: The aim of this policy is to minimize fall risks and ensure the safety and well-being of all residents while fostering a proactive and safety-conscious environment. Policy Statement: The Establishment is committed to reducing fall risks by implementing comprehensive prevention measures, promoting resident independence, and ensuring rapid response to incidents when they occur. Procedures 1. Risk Assessments: Conducted regularly for all residents upon admission and routinely thereafter. 5. Incident Response and Monitoring: * Prompt investigation and documentation of falls. * Implement corrective actions and maintain records to track trends and identify areas of improvement. * Monitor high-risk individuals more frequently."

R1's Service Plan, dated 10/11/24 documents that R1 utilized a walker, infrequently, or Wheelchair for ambulation, required supervision with transfer. R1's Service Plan also documents the service of an outside Hospice provider.

R1's Nurses Note, dated 6/2/2025 at 6:45 AM documents "Staff notified nurse of fall, vital signs T 98, P 74, R 16, B/P 136/70, O2 (oxygen) 96 %. Skin warm and dry, old bruises up and down arms still present and old skin tear to right elbow still present. Abdomen soft and non tender. BS x 4, no complaints of pain at this time. ROM (Range of Motion) with in normal limits, Neuro checks normal. Pupils Equal and reactive. No

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A4060	Continued From page 5	A4060		

injuries at this time. MD notified. Continue to monitor, Side rails up, bed and floor alarm in place and working." E4/LPN.

Upon observation of R1 on 6/5/2025 at 8:40 AM there are faded bilateral linear bruising noted to the neck approximately 1 inch in length and .5 inch wide. There is a healing skin tear noted to the left upper wrist area near the thumb that is approximately 1 inch linear with scab and minimal bruising.

Upon further review of R1's record, there is no documentation within R1's record of the skin tear noted to R1's upper wrist near thumb. There was no further monitoring of R1 documented after the fall from 6/2/25-6/5/2025.

E3/CNA's Witness statement, dated 6/3/25 documents, " On 6/1/2025, 11PM-7 AM I worked building A the morning of 6/2/25. I was assisting (R1) get ready for breakfast, he was changed and dressed in bed, underwear and pants only were changed. Once dressed, I sat him on side of the bed, asked (R1) to stand up, he did not, could not stand alone, I assisted him to stand. I lost footing, I became dizzy and we both fell going to the right. I grabbed him by shirt and stopped him from hitting head on rail, he was half off bed and half on floor. I managed to get up and assist (R1) up to bed sitting on side. rested on chair without problem. While in chair I put long sleeve blue shirt on, wheeled him in front of bathroom to brush hair, then once hair brushed pushed (R1) to table where he remained until I need my shift. I wrote statement about falling and gave it to E4/LPN on the morning of 6/2/25."

During interview with E2/LPN at 9:00 AM, on 6/5/2025, E2 stated, "R1 had a witnessed fall with

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A4060	Continued From page 6	A4060		

staff E3 on the morning of 6/2/25 while assisting R1 with dressing, Staff E3/CNA became dizzy and began to fall, staff grabbed R1's shirt to keep him from hitting the floor with increased force. E2 stated that E3 did not observe any injuries from the incident and reported to a Nurse that AM. The Nurse did do an assessment and there was some old bruising noted from previous falls, hitting his hands on tables, wheelchair etc. E2 stated that the bruise to his neck did not show up until 6/3/2025 when found by Z1/Hospice Nurse. E2 stated confirmed that besides E3/CNA and Nurse on 6/2/205, they were the only staff aware of the incident because no incident report was completed and no communication was discussed with off going shifts." E2 further stated that R1's fall on 6/2/25 was not reported to R1's spouse or to the Hospice staff.

On 6/5/2025 at 9:42 AM, E1/Manager and E2/LPN both confirmed that E3/CNA failed to completed an incident report at the time of the incident and failed to increase monitoring on R1 after the fall.

On 6/5/2025 at 11:00 AM, during telephone interview, Z2/R1's Spouse confirmed that she was not notified of R2s fall on 6/2/2025 until 6/3/2025 when bruising was noticed on R1's neck by Z1/Hospice Nurse.

On 6/5/2025 at 1:09 PM, Z1/R1's Hospice Nurse also confirmed that R1's fall on 6/2/2023 was not reported to the Hospice team and that staff on duty 6/2/2025 could not communicate what had caused R1's bruising to his neck. Z1 further stated that staff should be utilizing gait belts during transfers of the residents.