Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003792	A. BUILDING: ______ B. WING ______	C 07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER CITY REHAB & LIVING CTR	600 MAPLE STREET PIPER CITY, IL 60959

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S 000	Initial Comments Complaint Investigation 2365740/IL161940	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)3)6) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The	S9999		

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plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to implement fall interventions and provide supervision for a severely cognitively impaired resident (R1) at risk for falls, who required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. The facility failed to complete neurological assessments after R1's unwitnessed falls on 6/29/23 and failed to complete thorough fall investigations, including root cause analyses, and implement new fall interventions for R1. R1 had an unwitnessed fall in R1's bedroom on 7/2/23. R1 sustained a temporal laceration and was hospitalized with a Subdural Hematoma. R1 also required a blood transfusion due to blood loss at the time of the fall. R1 is one of eight residents reviewed for falls in a sample list of nine residents.

Findings include:

R1's Medical Record documents R1 was admitted to facility on 6/28/23 with medical diagnoses of Dementia, Parkinson's Disease, Bladder Disorder, History of Falls, Intellectual Disabilities, Anxiety, Muscle Weakness, Difficulty in Walking, Fatigue and Need for Assistance with Personal Care.

R1's Minimum Data Set (MDS) dated 7/2/23 documents R1 is severely impaired. This same

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MDS documents R1 required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene.

R1's Care plan includes a fall focus area dated 6/28/23 which documents three separate falls for R1 dated 6/29/23, 6/29/23 and 7/2/23. This same care plan does not include new fall interventions after each fall. This same care plan fall interventions are all dated 6/28/23.

R1's Fall Risk Assessment dated 6/29/23 documents R1 as a high fall risk.

R1's Physician Order Sheet (POS) dated July 2023 documents a physician order for Aspirin (antiplatelet) 81 milligrams (mg) daily.

R1's undated fall investigation documents R1 had an unwitnessed fall on 6/29/23 at 11:40 AM. This same report documents R1 was found sitting on buttocks on the floor in hallway with back leaning against the wall, bilateral legs stretched out in front of him in good alignment. This same report documents, "(R1) stated 'I got to go to the toilet'. Noted a 9.0 cm long skin tear to Right Elbow with small amount of blood noted. (R1) complained needing to use the toilet." R1's Fall investigation for R1's 6/29/23 fall at 11:40 AM does not include other resident or staff interviews. This same investigation does not include root cause nor new fall intervention for the fall.

R1's undated fall investigation for 6/29/23 fall at 7:36 PM documents R1 was observed laying on the floor on left side, yelling for 'Alma'. This same report documents R1 was confused and ambulating without assist. R1's fall investigation for R1's fall on 6/29/23 at 7:36 PM does not include other resident or staff interviews. This

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same investigation does not include root cause nor new fall intervention for the fall.

R1's Medical Record does not document a complete set of neurological assessments after R1's falls on 6/29/23 at 11:40 am or 6/29/23 at 7:36 PM. This same medical record does not document any new fall interventions in place after R1's falls on 6/29/23. This same medical record documents one set of neurological assessment after R1's 6/29/23 fall at 11:40 AM dated 6/29/23 at 1:26 PM. There are no other neurological assessments completed for R1. This same medical record shows R1 was toileted at 2:11 AM with no further assistance provided by staff before or after 2:11 AM on the 10:00 PM-6:00 AM shift of 7/1/23-7/2/23.

R1's Nurse Progress Note dated 7/2/23 at 5:15 AM documents, "(R1) was lying on floor mat but bleeding profusely from (R1's) head over Left Eyebrow area. Pressure applied to area. 911 called. (R1) was only moaning and verbalizing."

R1's Nurse Progress Note dated 7/2/23 at 5:30 AM documents emergency services arrived.

R1's Hospital Record dated 7/2/23 documents, R1's chief complaint as fall. This same record documents R1 was found on the floor at facility. The record documents, "Per emergency services personnel (R1) had approximately a liter of blood on the floor and the blood was coagulated. (R1) had a 2.5-centimeter (cm) laceration over Left temple. (R1) is cool and appears quite pale." This same record documents R1 had a "decrease in blood pressure with a systolic of 80. This is likely from the fair amount of blood loss that was on scene per emergency services. (R1) was given saline and one unit of blood and the blood

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pressure normalized." This same report documents (R1's) final diagnosis of Subdural Hematoma, Hyponatremia, Anemia and Laceration of Scalp.

R1's Computerized Tomography (CT) of the brain dated 7/2/23 documents, "Large Left Subdural Hematoma", "right midline shift."

R1's Final Incident Report to Illinois Department of Public Health (IDPH) dated 7/7/23 documents R1 had an unwitnessed fall on 7/2/23 at 5:15 AM. This same report documents, "Certified Nurse Aide (CNA) observed (R1) on floor mat beside bed. Observed bleeding coming from (R1's) head. Pressure applied to over Left Eyebrow. (R1) sent to hospital for evaluation and treatment. Computerized Tomography (CT) scan of Head reveals Left Tentorial Subdural Hematoma sizing 1.7 centimeters (cm) on coronal view, 4-millimeter (mm) midline shift. Three milliliter (ml) Left Frontal Subdural Hematoma also seen. Injuries noted Left Subdural Hematoma with laying of blood in Right Ventricle, 3-4 mm midline shift. Left Eyebrow laceration. Closure of laceration over Left Eyebrow. (R1) transferred to another hospital to trauma unit. 7/2/23 (R1) was intubated and sedated. Extubated on 7/4/23. Compression deformity at Superior endplate of T3 chronic. Mild anterior wedging of L1 chronic. Vertebral body possible compression fracture L6 TP fracture chronic. Age indeterminate avulsion fracture vs enthesopathy of Right Elbow chronic. Conclusion: It has been determined that (R1) hit head on ledge of baseboard when he attempted to get self out of bed. (R1) is known to attempt to self-transfer self from wheelchair and bed. The facility determined the fall happened most likely due to (R1's) diagnosis."

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On 7/21/23 at 11:35 AM V1 Administrator stated, "We (facility) were aware (R1) had one to one continual monitoring due to falls at the sister facility from where (R1) admitted from. We (facility) thought because we are better staffed and have a smaller census, we (facility) could try to keep an eye on (R1) better. We (facility) did not do continual checks or 15-minute checks. (R1) did fall two times on 6/29/23. I though there were interventions in place, but the fall interventions were added in on 6/28/23 before the three falls happened. We (facility) should have put in care plan interventions after each fall to try to prevent the other falls."

On 7/21/23 at 2:10 PM V4 Certified Nurse Aide (CNA) stated V4 started work at 4:30 AM on 7/2/23. V4 stated, "I knew (R1) was a high fall risk." V4 stated, "Did visual rounds a few minutes before 5:00 AM and observed (R1) asleep in his bed. I didn't wake (R1) up but I did see him. I had not checked (R1) for being incontinent and do not know when (V10) CNA changed (R1). I walked by again at 5:15 AM and saw (R1) laying on the floor so that is when I called the nurse. I think (R1) was trying to get up by himself to use the bathroom."

On 7/22/23 at 11:09 AM V21 Certified Nurse Aide (CNA) stated R1 was a known high fall risk. V21 CNA stated staff would keep R1 in a wheelchair at nurses' station to keep an eye on him. V21 CNA stated, "(R1) would try to get up by himself all the time. (R1) usually had to go to the bathroom. When (R1) would try to get up, we (staff) would take him to the bathroom and then he would calm down for a few minutes again. I heard (R1) died from that fall. That is awful."

On 7/22/23 at 3:00 PM V1 Administrator

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S9999	Continued From page 7 explained, "The night shift starts on the day before. So, if (R1) fell on the early morning of 7/2/23, then that information would be documented under 7/1/23 night shift. (R1) toileting documentation shows that he was toileted at 2:11 AM the night of 7/1/23 and early morning of 7/2/23. The documentation does not show any other time the staff assisted (R1) in any way. It looks like (R1) was only checked on at 2:11 AM. I cannot prove that (R1) was observed any other times during the night until 5:15 AM when (V4) CNA saw him on the floor. That might explain why there was so much blood." On 7/22/23 at 3:35 PM V22 (Medical Director) stated this facility should have included resident specific care plan interventions after each fall. V22 stated this facility should not have taken such a high-risk resident if they are not able to care for R1. V22 stated, "This facility does not have a Director of Nursing (DON) and the Administrator (V1) is not a nurse. They (facility) have no business taking on any high-risk residents without the staff or management to care for them. As far as the liter of coagulated blood, that reasonably does not make medical sense if (R1) only had the 2.5 cm laceration and was not on any other anticoagulants other than Aspirin. I was not made aware of this situation and would have to give it a closer look but from a global view, I believe the facility caused this injury by not monitoring (R1) closer. (R1) sounds like he definitely was a high fall risk and should have been on continual monitoring from admission." On 7/23/23 at 12:00 PM V9 Registered Nurse (RN) stated V9 was aware R1 was a high fall risk. V9 RN stated, "I worked with (R1) at his previous facility. They (previous facility) had (R1) on one-to-one, continual monitoring because he fell	S9999		

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so many times and kept getting hurt. (R1) had stitches, staples, fractures, you name it, he had it. (R1) would constantly get up by himself even after he came here (facility). (R1) would sleep most of the night and get up early. Apparently, that is what (R1) did that day (7/2/23). I did not witness any staff assisting (R1) that night." V9 RN stated V9 started medication pass at 5:15 AM on 7/2/23 right when V4 Certified Nurse Aide (CNA) came to report R1 fell. V9 stated, V4 said '(R1) fell. It is bad.' V9 RN stated when V9 got to R1's room R1 was laying on floor with R1's head leaning against baseboard and 'bleeding profusely'. V9 RN stated 911 was called immediately while V4 held pressure on R1's head. V9 RN stated, "There was so much blood. It was all over. At least a liter if not more."

On 7/23/23 at 12:30 PM V23 (Physician) stated R1 was a known high fall risk. V23 stated R1 was on one-to-one continual monitoring at a previous facility which did help reduce R1's falls. V23 stated the previous facility prevented several falls for R1 by placing R1 on continual monitoring. V23 Physician stated when R1 admitted to this facility R1 should have been placed on one-to-one continual monitoring. V23 Physician stated, "When (R1) admitted to this facility, I asked the staff if he was on one-to-one monitoring and they (staff) said no. I told them about (R1's) history of having been on continual monitoring for falls. If there were staff there to monitor (R1) then the staff could have encouraged (R1) to not get up on his own or been there to help him. They (facility) could have prevented (R1's) fall on 7/2/23 if there were fall interventions in place from his two falls on 6/29/23 and if there were one to one's in place. If they (facility) would have monitored and intervened earlier the risk of (R1) falling would

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have been greatly reduced or eliminated." V23 stated it is hard to say how long it would take to lose a liter of blood. V23 stated, "It would depend on many factors". V23 Physician stated it does sound like (R1) lost a great deal of blood because he received one unit of blood in the emergency room. V23 Physician stated, "It sounds like this facility needs to educate their staff on how to manage and reduce falls."

The facility policy titled 'Fall Prevention' revised 11/10/18 documents the facility will provide for resident safety and to minimize injuries related to falls, decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. All staff must observe residents for safety. If residents with a high-risk code are observed up or getting up, help must be summoned, or assistance must be provided to the resident. Appropriate interventions will be implemented for residents determined to be at high risk at the time of admission for up to 72 hours. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. The unit nurse will place the documentation of the circumstances of a fall in the nurses notes or an Assess, Intercommunicate, manage (AIM) for Wellness form along with any new intervention deemed to be appropriate at the time. All falls will be discussed in the morning Quality Assurance meeting and any new interventions will be written on the care plan.

The facility policy titled 'Head Injury' reviewed 12/22/17 documents head injuries to be evaluated for a minimum period of 72 hours to

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S9999	Continued From page 10 determine any negative effects and to allow for immediate treatment to minimize permanent damage. Procedures on proper assessment of residents who have sustained a head injury include: assess the resident including vital signs, consciousness and neurological status, immobilize resident's head and neck, ongoing assessment (vital signs and neurological checks) should take place initially and every 15 minutes for one hour, then every 30 minutes for one hour, then every hour for four hours, then every four hours for eight hours, then every shift for the remainder of 72 hours. Assessments for the first 24 hours after injury shall be recorded on the Neuro/Head Trauma Assessment form. Additional documentation shall be recorded in the clinical record. Complete a Quality Care Tracking form and document all observations and occurrences. (A)	S9999		