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
	IL6006597	A. BUILDING: ______ B. WING ______	10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE HALL NURSING & REHAB CENTER	620 WEST BRIDGEPORT WHITE HALL, IL 62092

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6) 300.1220)b)3) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 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: 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observations, record review and interview the facility failed to ensure adequate supervision to prevent multiple falls for 1 of 7 residents (R16) reviewed for falls in a sample of 62. This failure resulted in R16 fracturing her femur and continuing to have falls after the fracture.

Finding includes:

Throughout the survey from 10/16 through 10/24/18, R16 was observed propelling herself in her wheelchair. R16 was deaf and communicated

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to staff by using gestures or writing.

R16's Minimum Data Set (MDS) dated 7/14/18, documents that R16 needs extensive assistance from two plus person physical assist with transfers, walk in room, walk in corridor, locomotion on unit, and locomotion off unit. The MDS documents R16 needs extensive assistance from one person physical assist for bed mobility and toilet use. The MDS documented R16 had a Brief Interview of Mental Status score of 0, indicating severe cognitive impairment.

R16's Instant Care Plan upon admission, dated 10/12/17, documents that R16 had an actual fall and required fall precautions of bed/chair alarm, low bed, and Therapy.

R16's Care Plan dated 10/18/17 documents under problem that resident is at risk for falls due to immobility and noncompliance with transfers. Under goals: Resident will have no injury from falls thru next review 10/2018.

The Resident Incident Report documents on 3/27/18 at 2:31 AM, R16 was found on the floor. The Report documented R16 yelled and a staff member found her on the floor. The Incident Report documented she was sitting with legs straight out in front of her at foot of bed with noticeable shortening of left leg. The report documented she was sent to emergency room complaining of left leg pain. The report documented that R16 had inability to understand others and was deaf. The Post Incident Action form, dated 3/27/18, documented "Pee noted on floor where resident was sitting. Resident slipped in wet area and fell."

The facility provided four Falls Witness'

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statements, all dated 3/27/18, documented that R16 was attempting to go to the bathroom when she fell. These statements all documented there were no safety devices intact or alarming at the time of the incident.

R16's Care Plan was revised on 3/27/18 with interventions to offer toilet with bed checks, monitor for signs and symptoms of pain.

The Final Investigation Letter dated 3/31/18 documented R16 was alert with confusion and required assist of one for ambulation. The Letter documented she was found on the floor and was sent to the hospital and diagnosed with a fractured left hip. The report documented interventions were put into place, "mats on both sides of bed, therapy screen, B&B evaluation put into place."

R16's Resident Incident Report, dated 4/24/18 at 7:01 AM documented she was propelling herself in her wheelchair and fell out forward onto her knees. The Post Incident Actions report documented "monitor positioning of resident in wheelchair and reposition as needed, remind resident to slow down in wheelchair and not to lean so far forward, therapy to screen."

R16's Fall Risk evaluation dated 4/24/18 documents R16 scored an 80 indicating a High Risk for falls. According to the Fall Risk evaluation, scoring 46 and above is High Risk and to implement high risk fall prevention using the Falling Leaf Program.

The Resident Incident Report documents on 5/11/18 R16 was found sitting on the floor in her room. The Report documented R16 said she was pushing the w/c and walking behind it when the

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S9999	Continued From page 4 w/c got away from her and she landed on her buttocks. The Report documented R16 complained of left hip pain with rotation of the left foot. The Report documented she was sent to the ER. Post-Incident Actions, dated 5/11/18 documented "Rearranged room, personal bed alarm to wheelchair and bed." The Fall Witness Statement report, dated 5/11/18 documented R16 stated she was pushing her wheelchair and was walking behind it. The Statement documented "Take the w/c out of Resident room. Remind resident to ask for help. Resident is care planned for noncompliance of w/c." The Statement documents R16 had just eaten lunch, she has unsteady gait and she was pushing her w/c. Post Investigation Letter for the incident of 5/11/18, documents R16 fell and sustained a fractured femur. The Letter documented R16 was getting up without assistance to the bathroom and fell. This Letter documented the following interventions were put into place: monitor pain and administer medications as ordered; non-pharmacological interventions performed such as ice; notify physician of any changes; follow up with orthopedic as ordered; abductor pillow as ordered; rearranged R16's bed and wheelchair; and non weight bearing as ordered. The Care Plan was revised on 5/11/18 and documented to rearrange her room, abductor pillow as ordered, non weight bearing as ordered and personal alarm to wheelchair and bed. There was no documenation the facility reassess to determine the root cause analysis of R16's falls and her need for increased supervison. The Resident Incident Report documents on 5/28/18 at 8:20 AM, in her room, R16 was found	S9999		

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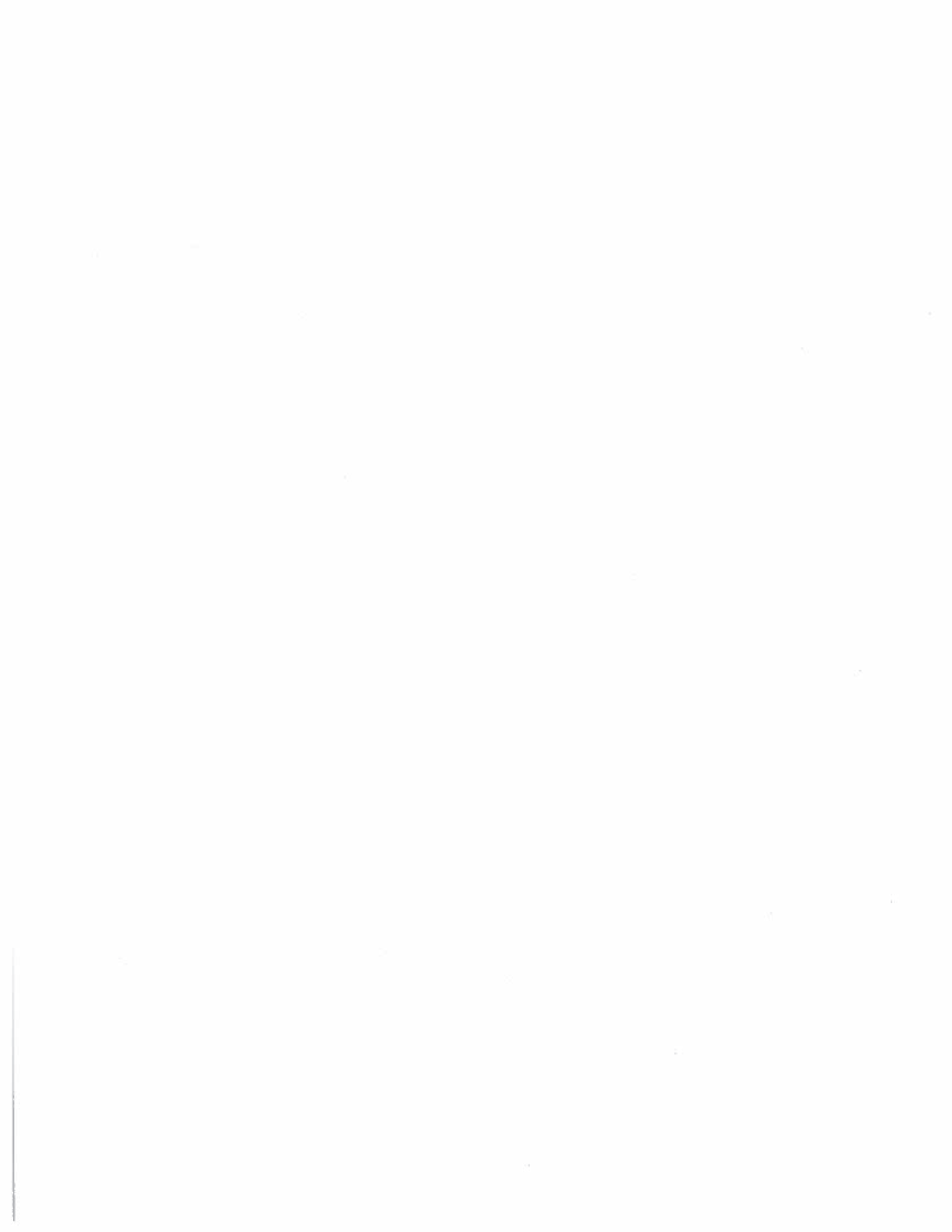
sitting on the foot pedals of her wheelchair by bathroom door. The Post-Incident Actions, dated 5/28/18 documented "resident assisted to bed and bed pan offered hourly, monitor for signs and symptoms of pain, continued therapy, PBA (Personal Body Alarm) sounding, resident continues to be non compliant with transfers and toileting." The facility had no further assessment to address R16's non compliance and need for further supervision.

The Fall Witness Statement report, dated 6/2/18, documents R16 was trying to take self to the bathroom. The Statement documented that no safety device was intact and alarming at the time of the fall. Another Witness Statement documented that R16 was last seen sitting in her wheelchair by her bed.

The Resident Incident Report documents on 6/2/18, at 7:20 PM, R16 was found in her room on the floor. The Report documented she was attempting to transfer herself from her wheelchair to bed and slipped from wheelchair to the floor. The Post Incident Actions, dated 6/2/18 documented to "offer resident to lay down at 7:00 pm if she desires, resident continues to be non compliant with transferring herself, continue therapy and PBA sounding." The facility had no documentation they reassessed R16 for her need for more supervision.

The Resident Incident Report documents on 6/4/18 at 8:53 AM, R16 was found in her bathroom. The Report documents she was attempting to go to the bathroom on her own and slid down onto her wheelchair legs. The Post -Incident Actions, dated 6/4/18 documented "Resident continues to be non compliant with call light and transferring herself, applied dycem to



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S9999	Continued From page 6 wheelchair, continue therapy, monitor for signs and symptoms of pain, PBA sounding." R16's care plan was updated with dycem in wheelchair cushion. The facility had no documentation they reassessed R16's non compliance and need for more supervision. The Resident Incident Report documents on 6/22/18 at 10:15 AM, R16 was again found in her bathroom alone. The report documented R16 was found sitting on the floor in front of the toilet leaning to R (Right) side. The Report documented she had toileted herself after removing her personal body alarm. The Report documented her hand slid off bar and she slid to floor. The Post-Incident Actions, dated 6/22/18 documented a transfer screen had been completed and R16 was changed to transfer of two assist to toilet instead of bed pan. The Resident Incident Report documents on 6/25/18 at 6:21 PM, another resident was trying to assist the resident to bed and R16 is non compliant with listening to staff for safety. The Report documents R16 was found on the floor in her room by her bed. The Post-Incident Actions, dated 6/25/18 documents R16's alarm was sounding, continue with therapy, toileting program still in place and she continues to be non-compliant. R16's Care Plan was reviewed on 6/25/18 with interventions monitor signs and symptoms of pain, continue therapy. The facility had no further reassessment to address R16's non compliance and need for more supervision. The Fall Witness Statement, dated 6/25/18 documents R16 last seen during supper. The Statement documented to prevent future falls "more people to help during supper so we can monitor the halls with 2 aides instead of one."	S9999		

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The Resident Incident Report dated 7/10/18 at 9:16 AM documents R16 was taking self to bathroom and upon going back to her chair she lost her balance and sat on the floor. The Post-Incident Actions, dated 7/10/18 documents "Pressure alarm that cannot be shut off by resident, non-slip socks, social services to do 1:1 activities."

The Resident Incident Report documents on 9/7/18 at 4:30 PM in her room R16 was found sitting on her buttocks leaning on the nightstand to her back. The Report documented that resident was trying to get in the bed and her chair slid backwards because her wheels were not locked. The Post-Incident Actions dated 9/7/18 documents the resident continues to be non compliant and anti-tipping device added to w/c wheel."

The Resident Incident Report documents on 10/01/18 at 11:15 PM in her room, Resident alarm was sounding and she was found in her room on her rt (right) knee, she slid herself out of her chair." The Report documented she sustained a small abrasion to her right knee. The Post-Incident Actions, dated 10/1/18 documented R16's "personal alarm is already in place, medication review, and continues to be non compliant, schedule routine pain medication per physician orders." The facility had no reassessment or care plan to address R16's need for more supervision.

The Resident Incident Report documents on 10/16/18 at 4:56 PM in her room R16 was found sitting on her buttocks in front of wheelchair. The Post-Incident Actions dated 10/16/18 documented gripper socks were placed on residents and the

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alarms were checked to make sure they were working properly.

R16's Care Plan, dated 10/17/18 was revised and stated to take resident to dining room at 4:30 PM and feed her and then take her back to room and lie her down. There was no documentation of the facility reassessing R16 for non compliance of self transferring and need for increased supervision.

The Resident Incident Report documents on 10/19/18 at 6:31 PM R16 in her room. The Report documented R16 fell while going from her w/c to her bed. The Care Plan was revised on 10/19/18 and documents dycem to mattress. There was no documentation the facility conducted an assessment to determine the root cause analysis of R16's falls and reassess her need for more supervision.

On 10/24/18 at 09:57 AM V2 (Director of Nurses/DON) stated that she hasn't been trained on the Falling Leaf Program.

On 10/24/18 10:07 AM V14 (Certified Nursing Assistant/CNA) stated that she was not sure what the "Falling Leaf program" was about.

On 10/24/18 10:07 AM V16 (CNA) stated that the Falling Leaf program was to indicate a person was a fall risk and that the person would have a leaf by their name tag on the wall next to their room to notify staff of it. V16 also stated that they haven't been doing that. V16 stated, "We have the "daily care guide" which has the fall risks on it."

On 10/24/18 at 10:45 AM V1 (Administrator) stated that they do not have a Falling Leaf

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Program. V1 stated, "We just use the Morse Fall Scale as an assessment guide. The nurses and CNA's have a pocket guide they use on the unit. I have done all I can do for (R16). I can't put her on 1:1; she will have a fit. I guess I will have to discharge her. Then who will take her? Nobody! Nobody is going to take her!"

The facility policy on Accident and Incident, Documentation and Investigation, Resident Incident revised 7/2018 documents under "Policy: Accident and/or incidents involving resident care will be investigated and documented on the Resident Incident Report entry form in the LTC system. An 'incident' is defined as an occurrence which is not consistent with the routine operation of the facility or the routine care of a particular resident. Accident and incidents will be analyzed for trends or patterns to enable the facility to enhance preventive measure to reduce the occurrence of incidents."

(B)