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	IL6002869	A. BUILDING: _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH REHAB CENTER	ONE PERRYMAN STREET LEBANON, IL 62254

(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
S 000	Initial Comments Statement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 Licensure Violations 300.610a) 300.1210b)4) 300.3240a) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	S9999		

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S9999	Continued From page 2 These Regulations were not met as evidenced by: Based on interview, observation and record review, the facility failed to provide timely reassessment, monitoring and services to maintain and/or improve ambulation abilities for one of 21 residents (R51) reviewed for activities of daily living in the sample of 21. This failure resulted in R51 declining in ambulation from 200 feet to barely making steps. Findings include: 1. R51's Minimum Data Set (MDS), dated 11/13/17, documented R51 as having severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 5. The MDS also documented R51 requires extensive assist of one staff for mobility and transfers. The Restorative Program PT/OT (physical/occupational therapy) program sheet, dated 5/15/17, documented R51 was ambulating 200 feet with a wheeled walker at that time by the two restorative Aides. On 12/26/17 for the lunch meal, R51 was propelled out of his room to the dining room by V21, R51's wife. R51 remained in his wheelchair for lunch. On 12/27/17 at 10:46 AM V12, Certified Nurse Aide (CNA) said R51 usually propels his own wheelchair but now they have to propel him so he needs to have the pedals on. V12 stated V21 asked about the pedals and why he had them. At 11:30 AM, V21 propelled him to the dining room in his wheelchair.	S9999		

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On 12/27/17 at 12:14 PM V12 and V28, CNA, positioned R51's wheelchair next to his bed and applied a gait belt. R51 was given cues to push up as V12 attempted to stand him up from the wheelchair. R51 was unable to stand at first then was lifted by V12. R51 did not move his feet to pivot to the bed but was pushed in the direction of the bed. V12 stated "sometimes he does better than others." At 12:18 PM, V12 was asked if R51 ever walks to dine and confirmed R51 was on the walk-to-dine restorative program "but if he's tired," she'll take him in the wheelchair.

On 1/3/18 at 11:25 AM, V21, R51's wife, stated she visits daily from morning to late afternoon. V21 stated R51 does not walk any more to the dining room adding that "(V12) tries to get him to walk into the bathroom from the dining room from bed." V21 stated R51 needs to use his legs more and staff need to stand him more. V21 stated R51 has declined with the last couple of falls he's had.

R51's Progress Notes documented falls on 11/23/17 and 12/11/17.

R51's Restorative Nursing Assistant Sheets, dated December 2017, has staff initials documenting restorative nursing was done daily from 12/1/17 through 12/30/17. The Intervention documented "Ambulate at least 200 feet with FWW (wheeled walker) with CGA (Contact Guard Assistance) as tolerated q-day (every day) 7 days a week." The Certified Nursing Assistant sheet intervention documented "Ambulate in a walk to dine program at lunch" with the wheeled walker every day 7 days a week and also had staff initials as done daily for the entire month of December 2017.

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Quarterly Assessments completed by V19, MDS Coordinator, dated 8/21/17 and 11/13/17, documented the same exact information and reflect R51's current goals for ROM and Restorative with no revisions noted.

On 1/3/18 at 11:38 AM, V19 and V3, MDS Coordinators/Licensed Practical Nurses, stated R51 was on a walk-to-dine program daily at the lunch meal and also on an ambulation program to walk daily. V3 and V19 were not aware that R51 was no longer walking to the dining room ambulating with the restorative person. Neither one could explain why the programs were documented as being done when they were not. Both stated R51 had not been reassessed since his decline.

On 1/4/18 at 7:55 AM, V22, Restorative CNA stated R51 has "really declined" since his last fall. V22 stated R51 will take a "few steps" on a good day. V22 stated he reported the decline to V19. V22 stated yesterday (1/3/18) that he helped another CNA to transfer him and R51 was barely able to bear weight. V22 stated R51 was "not even feeding himself" anymore.

On 1/4/18 at 8:30 AM, V2 Director of Nurses (DON) stated V19 requested a therapy evaluation which is going to be done today.

The facility's policy/procedure entitled "Restorative Nursing Program (RNP)" dated November 2017 documents "A Referral to the Restorative Nursing Program can occur at the termination of therapy services or at any time the resident is deemed appropriate for the program. To this end, a resident may move from skilled therapy to concurrent skilled and restorative

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intervention as a progression through treatment. The therapist (Physical, Occupational or Speech) will document which parts of the program are to be executed under the RNP and which are benign carried out under skilled therapy. The Objective documents the Restorative Nursing Program is designed to foster maximum independence in functional activities through facilitation of newly learned or rehabilitated skills. The policy also documents the restorative program will be recorded by nursing and must document objective goals, approaches, frequency, and duration of the program. The policy documents a progress note summarizing resident status written by a licensed nurse will be done at least quarterly or with any MDS assessment where restorative information is captured. "Any change of condition affecting functional status should result in a referral to therapy. Therapy will evaluate the resident and determine the appropriate action."

(B)

2 of 2 Licensure Violations

300.610a)
300.1210b)
300.1210d)6)
300.3240a)

Section 300.610 Resident Care Policies

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S9999	Continued From page 6 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999		

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S9999	Continued From page 7 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision, develop and implement effective interventions to prevent falls for one of 8 residents (R51) reviewed for falls in a sample of 21 and 1 resident (R100) outside the sample. This failure resulted in R51 receiving a head injury that required sutures from two subsequent falls, and R100 receiving a left hip fracture requiring hospitalization after a fall. Findings Include: 1. R100's Care Plan, revised on 3/10/2017, documented R100 had the following diagnoses: Urinary incontinence, muscle weakness (generalized), lack of coordination, difficulty	S9999		

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walking, transient cerebral ischemic attacks (TIA) and related syndromes, Hemiplegia and Hemiparesis following cerebrovascular disease affecting unspecified side, fatigue, abnormal posture, and vascular dementia.

Fall Risk Assessments dated 5/18/2017 and 8/09/2017 documented R100 had a history of falling with a score of 60. The Fall Risk Assessments documented a score 45 or higher, indicating a high risk for falls.

The Facility's Verification of Incident Investigation/Administrative Summary, dated 5/21/17 at 5:00 PM documented R100 was found on the floor with the follow-up action being, "Educated resident to have family ask for assistance from staff & (and) educated family to not take R100 to bathroom without asking staff's assistance."

The Facility's Verification of Incident Investigation/Administrative Summary, dated 7/14/17 at 12:30 PM documented R100 "fell in room," and the follow-up actions taken being, "Monitor for further injury x(times) 72 hours. Educated resident to ask for assist instead of putting self in harm's way."

R100's Minimum Data Set (MDS), dated 8/9/2017, documented R100 had a Brief Mental Status score of 8, indicating moderately impaired cognition. R100's MDS documented R100 required extensive assistance with toileting.

R100's MDS dated 10/03/17, documented R100 had moderately impaired cognitive skills for daily decision making and required extensive assistance with toileting.

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R100's Progress Note, dated 10/3/2017 at 11:19 PM documented R100 had a fall in the bedroom during self ambulation from bathroom, during nursing rounds on the floor in the bedroom and requires staff assistance with transfers. R100's Progress Note documented R100 was unable to move his left, lower extremity and the extremity was turned outward.

The Facility's Situation Background Assessment Recommendation (SBAR) dated 10/3/2017 documented " 1. Res (resident) fell during self elevation, unable to move L(left) hip, LLE(left lower extremity) rotates outward."

The Facility's Verification of Incident Investigation/Administrative Summary dated 10/3/17 at 11:22 PM documented R100 "fell outside bathroom door after taking self to bathroom. Assessment: fall with L(left) lower leg shorter than R(right). Sent to ER (Emergency Room) for eval (evaluation): Admitted c(with) hip fx(fracture)." Follow-up actions taken:"Resident is not a good candidate for surgery going to hospice in the hospital."

The Hospital History and Physical, dated 10/04/17, documented "(R100) presented to the ED (Emergency Department) after a fall resulted in left hip deformity. Medical History: Neurological: Alzheimer's Disease/Dementia, CVA(Cerebrovascular Accident). Physical Exam: (R100) is not oriented to place or time. R100 is not able to reliably follow commands or expressed R100s wishes. Assessment/Plan since the patient was wheelchair-bound only functional return that would likely occur with surgery would be been able to sit up in bed for eating meals and using the commode the family is very interested in pursuing non-operative

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options including pain control and hospice palliative care."

R100's Care Plan, dated 10/3/17, documented R100 was at risk for falls related to paralysis, gait/balance problems, and incontinence. R100's Care Plan documented Interventions/Tasks, "(R100) sent to Emergency Room and was admitted with left hip fracture. Following fall in facility on 10/3/17. Review information on past falls and attempt to determine cause of falls. Educate resident/family/caregivers/IDT(interdisciplinary team) as to causes." R100's Care Plan also documented an intervention for the 10/3/17 fall "Resident educated regarding calling for assist with transfers. Other interventions listed for previous falls on R100's Care Plan were as follows: "Date initiated on 7/29/2016: Resident educated on asking for assistance and to not attempt to self transfer;. Date Initiated 10/17/2016: Resident educated regarding calling for assist with transfers; Date Initiated 07/14/2017: Educated resident to call for assist with turning on and off air conditioner. The Care Plan fails to address updated, effective interventions after each fall. There is no intervention listed for the 5/21/17 fall.

On 12/29/17 at 2:11 PM, V17, Certified Nurse's Aide (CNA), stated V17 wasn't the one to find R100 when R100 fell on 10/3/17. V17 stated R100 "sometimes got up to go to the bathroom by R100s self, and R100 would do that more in the night time. Staff was aware of that." V17 further stated R100 would use the urinal to urinate, but when R100 had to have a bowel movement, R100 would use the toilet. V17 further stated V17 cared for R100 on a consistent basis.

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On 1/4/18 at 10:40 AM, V29, Licensed Practical Nurse (LPN), stated that R100's fall happened in-between shift exchange. V29 stated most times V29 worked as the nurse caring for R100. V29 stated R100 was confused and was not to ambulate to the bathroom, as R100 was at the minimum assist of one, and sometimes a transfer assist of two, with toileting. V29 further stated R100 did get up on R100s own and V29 found R100 on the floor by R100s bed and R100s wheelchair was "next to the door where the aides left it."

On 01/04/18 at 12:55 PM, V31, Medical Director, stated in part it is the expectation of the facility to have interventions in place to prevent falls, and to revise effective interventions based on the causative factor of each fall.

2. R51's MDS, dated 11/13/17, documented R51 had severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 5. The MDS also documented R51 required extensive assist of one staff for mobility and transfers. The MDS documented R51's balance was unstable and R51 was only able to stabilize with staff assistance.

Verification of Incident Investigating/Administrative Summaries show R51 had had multiple falls since R51s admission on 3/2/17.

R51's Care Plan, dated 3/5/17 documented staff are to review past falls and attempt to determine cause of falls, report possible root causes and after remove any potential causes if possible. The Intervention added as a revision was to

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"have resident's wheelchair brakes inspected and to have anti roll back placed on R51s wheelchair."

The Verification of Incident Investigating/Administrative Summary dated 4/1/17 documented R51 was found in the bathroom on the floor at 3:45 pm. The report documented R51 fell from the toilet. The report documented Interventions which included a personal alarm on R51s wheelchair and a low bed. There is no information as to whether R51 had an alarm on and if it was sounding and if R51 attempted to toilet R51s self or was attended by staff.

On 1/4/17 at 11:45 AM, V2, Director of Nurse's (DON) stated on 4/1/17, R51's wife put R51 on the toilet by herself and R51 fell off. V2 stated R51's wife was educated. V2 stated R51 had a wheelchair alarm initiated on admission and it was on that day but the wife removed it.

The Verification of Incident Investigating/Administrative Summary dated 9/18/17 at 2:20 AM, documented R51 was "found on the floor next to R51s bed. R51 said 'I slipped on the rug. Resident alarms (bed/chair) recently dc'd (Discontinued) due to maintain compliance with CMS (Centers for Medicaid/Medicare Services)". The interventions includes orders for a concave mattress and keep bed in lowest position but did not address R51s need for additional supervision or his tendency to get up unattended as a problem.

The Verification of Incident Investigating/Administrative Summary, dated 10/3/17 at 9:30 PM, documented R51 was again found on the floor between the bed and the wall. The summary documented "resident is in (low)

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bed" and "waiting for concave mattress to be delivered. Resident has a recently increase uric acid level and gout." The care plan dated 12/17 fails to reflect any new interventions put in place in response to this fall.

A copy of the invoice for the concave mattress documents it was delivered 10/10/17.

The Verification of Incident Investigating/Administrative Summary, dated 11/23/17 at 10:00 PM, documented R51 sustained a "laceration Left upper forehead" when R51 "bumped R51s head on the bed during ADL (Activities of daily living) care." The report documents the laceration to be 3 cm (centimeters) by 1/4 cm. No further interventions were put in place to prevent this from occurring again according to the care plan and investigative summary. The causative factor is not identified.

On 1/3/18 at 2:09 PM, V2, Director of Nurses (DON) provided two statements from the CNA's, V26 and V25, who were providing ADL care when R51 sustained the 3cm laceration to his forehead.

V26's statement dated 11/24/17 documents "(R51) was being changed + (and) R51 reached over + grabbed siderail + pulled R51s self into the rail." V25's statement documented R51 "pulled R51s self into the siderail and banged R51s head."

No interventions or revisions to the care plan were completed/documented in response to this incident to prevent further occurrences.

The Verification of Incident Investigating/Administrative Summary, dated 12/10/17 at 10:00 pm, documented R51 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002869	A. BUILDING: _____ B. WING _____	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH REHAB CENTER	ONE PERRYMAN STREET LEBANON, IL 62254

(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
S9999	Continued From page 14	S9999		

again found on the floor next to the bed. The assessment documented R51 had a laceration to R51s left forehead and cheek and a skin tear to left arm. R51 was transferred to the emergency department for treatment.

The Situation Background Assessment Recommendation (SBAR) dated 12/10/17 documents "resident was found in room next to bed on the floor with left side of head facing downward. Laceration to forehead and cheek bone noted to left side of face, left eye swollen shut." The Episodic Fall Care Plan section documented R51 had bed rails on, a sensor pad alarm in bed, and a low bed with a mattress on the floor.

Progress notes document R51 was transferred out to the emergency department for sutures and returned to the facility on 12/11/17 at 3:46am. There is no documentation on the laceration until 12/21/17 when it was measured after the sutures were removed on 12/18/17. The laceration measured 2cm x 2cm x 0.1cm on 12/21/17.

On 12/27/17 at 10:42 AM, R51's wife, V21, said R51 fell and had sutures recently. V21 stated that is why R51 came to the nursing home because R51 would fall at home and she couldn't get R51 up. V21 said R51 has had several falls since his admission. V21 said typically R51 did not move around in bed or was restless stating R51 would just lay flat and sleep. R51's forehead, cheek and eye area had light yellow, green bruising with a noted healed laceration area about R51s left eye. R51 also had a large scabbed area on upper left shoulder and forearm. R51's bed had a concave mattress on it and a thin mattress for beside in the bedroom.

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S9999	Continued From page 15 On 1/4/17 at 10:25 AM, V2 stated R51's alarm was discontinued on 9/12/17 as the facility started to phase out the alarms for everyone in the building. There was no documentation the facility determined causative factors in each of the falls R51 had or if there was a pattern since two of the falls occurred at bedtime and one other in the bathroom. The current care plan did not address R51's need for added supervision given the discontinuation of the alarm, possible toileting needs or R51s cognitive impairment and inability to use a call light or involve R51s self in activities. Facility Policy entitled Fall Management, dated August 2014, documents in part, "Purpose To evaluate risk factors and provide interventions to minimize risk, injury, and occurrences. Fall Prevention Procedure 1. Evaluate risk factors for sustaining falls upon admission, with comprehensive assessment, and while conducting interdisciplinary care plan reviews. 2. Initiate a fall prevention care plan when appropriate with strategies to minimize risk and potential for injuries. 3. Review, revise, and evaluate care plan effectiveness at minimizing falls and injuries during IDT (interdisciplinary) walking rounds and as needed. Care Plan Documentation Guidelines. Problem: Identify fall risk and associated risk factors. Goal: Document goals for minimizing falls and injuries. Approaches: outline fall prevention strategies and approaches." (A)	S9999		