

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007751	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2020
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NAME OF PROVIDER OR SUPPLIER RED BUD REGIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 350 WEST SOUTH 1ST STREET RED BUD, IL 62278
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S 000	Initial Comments Licensure Findings Complaint #2047169/IL126674 F689 cited	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.3240a) 300.610a) 300.1210b) 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. 300.1210d)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. 300.3240a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE 	(X6) DATE 09/25/20
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S9999	<p>Continued From page 1</p> <p>300.610a) 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.</p> <p>These Regulation was not met as evidenced by:</p> <p>Based on interview and record review the facility failed to assess, identify causative factors contributing to falls and implement safety measures for 1 of 3 residents, (R2) reviewed for falls in the sample of 7. This failure resulted in R2 falling, being admitted to the hospital for a left fracture of her femur (long bone or thigh) requiring surgery.</p> <p>Findings include:</p> <p>R2's Minimum Data Set, (MDS), dated 5/27/2020 documents, R2 was cognitively intact for daily decision making and has no impairment. R2's MDS also, documents R2's balance is not steady, and she is able to stabilize only with staff assistance for walking, moving from a seated position to a standing position, turning around,</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>moving on and off the toilet and surface to surface transfers, (between bed and chair or wheelchair). R2's MDS, also documents R2 has lower extremity impairment on one side, uses a walker and wheelchair and R2 is an extensive assist of 2 plus persons, (staff provide weight bearing support) with bed mobility, transfers, dressing and toileting.</p> <p>R2's Physician Order Sheet, dated 5/2020 document, R2 has a diagnosis of a fractured left femur, subsequent encounter for fracture with routine healing, presence of left artificial hip joint, fracture of unspecified part of right clavicle subsequent encounter for fracture with routine healing, pain in left hip, unsteadiness on feet, history of falling.</p> <p>R2's Care Plan undated document R2 at risk for falls, related to gait/balance for falls, related to gait/balance problems and (R2) is unaware of safety needs. She was admitted with a clavicle fracture, related to a fall at home.</p> <p>R2's Risk Assessment dated 5/04/2020, documents, R2 was at "high risk" for falls, history of falls, impaired gait, difficulty rising from the chair, poor balance and weak gait.</p> <p>On 9/09/2020 at 4:30 PM, R2 stated, I am currently living with my son here in Colorado. I was at the (Facility) because I had a fall at home. I was at the nursing home to get care and get better. I remember the fall back in May, because I fractured my hip and had to have surgery; the nurse came into my room and when she left, she left the lights on. I don't like the lights on when I am trying to sleep and usually, they turn the lights off, that night they left the lights on. I put on my call light and waited and waited and nobody</p>	S9999		

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S9999	Continued From page 3 came. I waited at least 30 minutes maybe longer, I was tired. I was supposed to be discharged in 2 days, so I decided I would turn off the lights because, I didn't think anyone was coming to shut them off for me. When I tried to grab the light switch cord, I fell backwards and landed on the floor. I was laying there and calling out for help. I kept calling out for help, but nobody would come. I probably waited another 20-30 minutes for someone to come help me. I then called my son to help me, he was in Colorado. On 9/8/2020 at 4:40 PM, V15, Family of R2 stated, "I live in Colorado and when (R2) fell that night she told me she had been yelling out for help, but no one was answering her. She called me on her cell phone and then I called the facility and told them to go and check on her because she had fallen. (R2) was at the facility because she had fallen at home. I just don't understand why there were not any fall precautions in place and why they were not checking on her. (R2) was there because, she fell at home and fractured her hip. You don't expect to put your loved one in a home and get a call on your cell phone asking you to help them because no one was checking on them and (R2) had fallen." On 9/10/2020 at 4:35 PM, V17, Licensed Practical Nurse, (LPN), stated, "Yes, I remember (R2's) son calling us on the phone and telling us his mother had fallen and to please go and check on her. He was really upset, and we rushed to (R2's) room and found (R2) on the floor she was complaining about pain, so we sent her out to the hospital." R2's Nurses Notes dated 5/12/2020 at 9:39 PM,	S9999			

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S9999	<p>Continued From page 4</p> <p>documents, "Resident son called this nurse at 7:55 PM, explained resident was in room on floor. This nurse and Certified Nursing Assistant, (CNA), immediately went down to resident room.</p> <p>Resident was on floor next to first bed. Resident stated, when she turned with her walker, she slipped and fell on bottom. Resident stated left leg was hurting. No redness, swelling, or bruising noted. No other injury noted. Resident continues to complain of left sided leg pain. Order to send resident to Emergency Room, (ER), for evaluation at this time."</p> <p>R2's Nurses Notes dated 5/12/2020 at 9:39 PM, "Orders to send Resident to ER for evaluation."</p> <p>R2's Nurses Notes dated 5/13/2020 at 12:55 AM, "Resident admitted to hospital at this time."</p> <p>R2's Nurses Notes dated 5/13/2020 at 12:56 AM, "Resident admitted to (hospital), related to left fracture to femur. Power of Attorney (POS) to be updated in the AM of admitting diagnosis."</p> <p>R2's Nurses Notes dated 5/15/2020 at 3:04 PM, "I called and spoke to nurse at (Hospital) and she said resident had nailing of the femur on 5/14/2020 and doing well."</p> <p>R2's Fall Report dated 5/12/2020 at 11:08 PM, documents, "Residents son called this nurse at 7:55 PM explained resident was in room on floor. This nurse and CNA immediately went down to resident room. Resident was on the floor next to first bed. Resident stated when she turned with walker, she slipped and fell on her bottom. Resident stated her left side leg hurts from hip to bottom of foot. No redness, swelling or bruising noted, Vitals within normal limits."</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>R2's Hospital Records dated 5/12/2020 document, R2 was sent out to the Emergency Room for a fall on 5/12/2020 and was admitted for a left displaced femoral neck fracture and R2 had a left hip hemiarthroplasty surgery on 5/13/2020. Per Emergency Room, (ER), Notes dated 5/12/2020, "(R2's) chief complaint left hip pain, presented with a fall from her nursing home. she was walking to bed after turning out the lights and fell to the ground after tripping over her chair."</p> <p>On 9/11/2020 ay 9:04 AM, V19, LPN, stated, "I vaguely remember (R2) had fallen and (R2) could not reach the call light but she could reach her phone, so her son called us and told us she had fell. I am not sure how long she had been on the floor I can't really say it was so long ago."</p> <p>On 9/11/2020 at 11:21 AM, V20, LPN stated, "I was not taking care of (R2) that night but, I do remember (R2's) son called and told us she had fallen in her room."</p> <p>On 9/11/2020 at 12:14 PM, V16, Physician stated, "(R2's) fall initially occurred at home she fell down the stairs, poor thing. Initially she was on acute care she came in on 4/01/2020 to 5/01/2020 she was on Physician Therapy the whole time and there were some issues with her not progressing fast enough I was told she had improved. I would expect call lights to be answered as soon as possible depending on what else is happening in the building. Yes, I would agree we expect staff to find residents on the floor rather than getting a phone call that a resident has fallen from a family member."</p> <p>The Facility's Fall Policy dated 2/09/2012</p>	S9999		
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S9999	Continued From page 6 documents, "Based on previous evaluation and current data, the staff will identify intervention related, to the resident's specific risks and causes to try to prevent the resident from falling, and to try to minimize complications from falling." (A)	S9999			