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
	IL6014294	A. BUILDING: ______ B. WING ______	C 12/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER HEALTH CARE CENTER	1601 BUTTERFIELD TRAIL KANKAKEE, IL 60901

(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 Complaint Investigation 2079489/IL129217	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.1220)b)3) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. 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 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)	S9999		

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These requirements were not met as evidenced by:

Based on interview and record review the facility failed to ensure safety interventions were in place for a resident with a history of multiple falls. This failure resulted in R1 falling in her room and found on the floor and sustained a left hip fracture. This applies to 1 of 3 residents (R1) reviewed for safety in the sample of 3.

Findings include:

The Final Incident Report dated June 23, 2020 documents R1 has diagnoses including anxiety, gait abnormality, fall history, and cognitive and behavioral changes. On June 19, 2020 at 3:30 PM, staff heard an alarm sounding and found (R1) on the floor in between her wheelchair and the doorway. (R1) has a history of multiple falls and her last fall was on June 15, 2020 (4 days prior). (R1) has a history of anxiety and can appear guarded and paranoid. (R1) was sent to local hospital and the imaging results showed R1 had left hip fracture. (R1) underwent surgical intervention.

R1's hospital records dated June 19, 2020 documents R1 comes in for a fall she sustained while trying to hang her menu on the door, when she slipped on the floor on her left leg. R1 states she in in severe pain. The x-ray report dated June 19, 2020, showed R1 has left hip fracture and underwent surgical intervention on June 20, 2020.

The Minimum Data Set assessment dated April 24, 2020 shows R1's cognition is impaired and requires assistance with transfers.

R1's Fall Risk Assessment dated April 19, 2020

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shows a score of 40. A score of 10 or more puts the resident at a high risk for falls.

R1's Fall Review dated June 5, 2020 documents R1 spilled her drink while eating and attempted to get up without assistance. R1 was found on the floor laying at the foot of her bed. Skin tears to her left eyebrow, left knee and shoulder. R1 told staff she was crawling to get help.

R1's Physician Progress note dated June 9, 2020 documents R1 was seen today for a fall. R1 fell sometime over the weekend and hit her face and sustained a small laceration over her left eyebrow. Bruising is noted to her left eye. R1 is impulsive and has poor recall and needs constant reminding to ask for help.

R1's Physician Progress note dated June 16, 2020 documents R1 was seen today for altered mental status and had two falls last night (On June 15, 2020). R1 is impulsive and does not ask for help.

R1's Physician Progress note dated June 19, 2020 documents R1 was seen today for on-going monitoring of previous confusion and fall on 6/15/2020. R1 appeared guarded and somewhat paranoid. R1 exhibits anxiety, paranoia, impulsive, she is forgetful and has poor recall.

R1's Fall Report dated June 19, 2020 documents the nurse heard a chair alarm sounding and upon entering the room (R1) was found lying on her back between the wheelchair and the doorway to the hallway. The nurse attempted to do a head to toe assessment on R1, but she was complaining of pain to her left hip and thigh. R1 was "wearing plain socks and not non-skid footwear." Staff were uncertain if the wheelchair had been in a

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locked position. R1 had been impulsive several times during the day needing frequent redirection. X-ray films revealed a left hip fracture. R1 had surgical intervention on June 20, 2020.

R1's Fall Huddle Form dated June 19, 2020 documents R1 had a fall at 3:30 PM, she is alert to person and does not know the month, R1 stated is was winter (during the month of June). R1's type of footwear worn at the time of the fall were socks and her safety interventions included to be seated in the dayroom for closer observation.

On December 11, 2020 at 10:40 AM, V4 (Restorative Nurse) said she conducted R1's fall investigation and it was discovered R1 was not wearing non-skid footwear and her wheelchair was not locked when she fell on June 19, 2020. V4 said R1 had a history of falls, impulsive and had been anxious and antsy the day she fell. V4 said R1 should have been placed on closer supervision especially that day due to her increased behaviors.

On December 11, 2020 at 11:45 AM, V3 (Assistant Director of Nursing) said R1 was very impulsive. V3 said staff should implement the fall interventions in place for a resident. V3 said fall interventions should be updated after each resident's fall.

On December 12, 2020 at 9:45 AM, V5 (Registered Nurse) said she was R1's nurse the day she fell on June 19, 2020. V5 said "I guess" her fall interventions are in the care plan. V5 said she does not look at the care plan and stated "I don't know" how to access the care plan.

R1's Care plan shows at risk for falls with

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S9999	Continued From page 5 interventions include to assist resident to wear non-skid footwear and place R1 in a recliner in the dayroom for closer observation when she is up. R1's care plan does not include new interventions after her fall on June 5, 2020. The facility's Fall Risk and Prevention/Reduction Policy revised Policy dated February 2018 states, "Riverside Miller Rehabilitation will provide a safe environment by taking actions to reduce the risk of falls during a residents stay...If a resident is at risk for falls, then the interdisciplinary team will initiate the following protocol...provide appropriate supervision...document interventions in clinical record. (A)	S9999		