STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013023	A. BUILDING: _____ B. WING _____	C 06/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI RESTORATIVE CARE	1455 HOSPITAL ROAD SILVIS, IL 61282

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S 000	Initial Comments Statement of Licensure Violations Complaint Investigation 1823567/IL103075	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 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	S9999	Attachment A Statement of Licensure Violations	

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a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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

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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 300.3240 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 observation, interview and record review, the facility failed to develop a care plan for a resident with a history of falls (R1), failed to provide adequate assistance during a transfer (R1 and R3), and failed to implement fall interventions to prevent further falls (R2) for three of three residents (R1, R2 and R3), reviewed for falls, in a sample of three. This failure resulted in R1 sustaining a complex, comminuted fracture of the right leg.

FINDINGS INCLUDE:

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The facility policy, Fall Prevention, dated (revised) 7/19/17 directs staff, "Residents of (the facility) will be evaluated for risk of falling at admission and throughout their stay in the facility. Residents determined to be at high risk for falling will receive appropriate interventions (care plan) to minimize risk. Interventions will be implemented to minimize the risk of resident falls, while addressing the specific needs of each resident. Following a fall by a resident, immediate interventions will be put in place.

1. R1's (Hospital) Transfer Form, dated 4/17/18 documents the following history, "(R1) presented to the ED (Emergency Department) for a fall. (R1) reports losing footing on gravel just prior to admission, falling onto left side and hitting head against (a) tire. (R1) was assisted up from the ground several times, but fell each time." This same form documents R1's Pelvic X-Ray (radiograph): Severe osteoarthritis in the right hip, R1's Right Knee X-Ray: Severe tricompartmental osteoarthritis, and R1's Computerized Tomography of the Lumbar Spine as: Moderate to severe multilevel degenerative facet disease. This Transfer form includes the following diagnoses on discharge as: Falls, Contusion of left knee, Contusion of right knee, Acute bilateral low back pain, Injury of head, Debility and Generalized Weakness. Also included in this same document are physician orders for Physical Therapy and Occupational Therapy.

R1's Care Plan, dated 4/18/18 contains no mention of R1's history of falls or no interventions to prevent further falls.

R1's Minimum Data Set Assessment (MDS), dated 5/1/18, completed just prior to R1's

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discharge documents R1's Cognitive Patterns (Section C0500) as 15 (cognitively intact). This same assessment documents R1's Balance During Transitions and Walking (Section G0300) as a "2" (not steady, only able to stabilize with staff assistance) while performing a surface to surface transfer.

R1's Physical Therapy Note, dated 5/7/18 documents R1's functional status as, 'Transfers-modified independence. (Requires) Assistive device during transfers: four-wheeled walker."

R1's Nursing Progress Notes, dated 5/8/18 document, "0530 (5:30 A.M.) Called to resident room by CNA, when entered room resident was sitting on scale with left leg extended out and right leg bent at knee with right foot under left knee."

On 6/5/18 at 11:10 A.M., V2/Director of Nurses (DON) stated, "I was the nurse on duty the morning that (R1) fell. I got a call from V3/Certified Nursing Assistant (CNA) to come to R1's room. (R1) was sitting on the scale with (R1's) right leg under (R1's) left leg. V3/CNA had gotten (R1) up for (R1's) morning weight. (R1) said (R1's) knee gave out. V2/CNA and I used the (mechanical) lift and put (R1) into bed. I called immediately and got an order for an X-ray (of the right knee). The (X-Ray) Tech (technician) called back right away and said it was fractured, but she had to wait until the Radiologist came in to officially read it. I kept (R1) informed of the situation and we kept (R1) on bedrest. (R1's) doctor had came into the facility to see patients that morning and I informed him of the situation. The doctor told me to call the (local orthopedics group). (R1) told me to ask for (V6/Orthopedic Surgeon) because R1 had seen (V6) in the past.

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(V6) stated to send R1 to the local Emergency Department."

On 6/5/18 at 1:20 P.M., V3/CNA stated, "I was supposed to get a daily weight on (R1) (5/8/18). (R1) had complained of pain in (R1's) left arm earlier in the shift. I had helped (R1) put (topical analgesic) on (R1's) left arm, earlier. (R1) didn't want to get on the scale. (R1) refused often. I kept talking to (R1). (R1) stood up fine. I didn't use the walker. (R1) yelled out, 'My knee.' (R1) lowered (R1's) self onto the scale."

On 6/5/18 at 3:30 P.M., R1 stated, " I fell (5/8/18). I lost my balance and fell. I fell onto the scale. My knee was up against the front of the scale. I couldn't get hold of the bar with my left arm. It was weak. I had injured it previously. I told (V3/CNA) my arm was weak that morning, but (V3) insisted I try. I had to remind (V3) to put a gait belt on me. (V3) wasn't going to use one. I never did get to a standing position. I fell immediately. (V3) did not give me my walker to use. (V3) tried to do it by herself. I kept telling (V3) to go get help. They sent me to (out-of-state) hospital, where they had to do special surgery on my knee. I just got to (other skilled nursing facility) recently. I'm going to be here for a long time for therapy. My knee is painful."

R1's (Emergency Department) Notes, dated 5/8/18 document, "(R1) presents with right leg pain. (R1) presents from (nursing facility) post fall. (R1) was getting up with assist of a belt for a weigh in when (R1)'s arm gave out and (R1) fell forwards. States that (R1) landed hard on (R1)'s rear and right knee. Has acute pain in low back and right knee." This same document includes the following diagnosis: Complex communuted fracture of distal end of right femur."

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R1's Radiology Report, dated 5/8/18 documents, "There is an acute comminuted fracture of the distal femur, just proximal to the femoral hardware component of the right total knee arthroplasty. There is complete medial displacement of the principal distal fracture fragment. Marked surrounding soft tissue swelling."

R1's Orthopedics Progress Note, dated 5/8/18 and signed by V7/Orthopedic Surgeon documents, "I was called in regards to (R1's) right distal femur complex periprosthetic fracture. I reviewed the X-rays and talked with my partners about the films. Due to (R1's) complex medical history and morbid obesity associated with (R1's) fracture, recommendation is to transfer to a tertiary care center. The worrisome appearance of (R1's) lateral femoral condylar attachment and paucity of bone surrounding the prosthesis makes it uncertain if standard ORIF (open reduction and internal fixation) would provide enough fixation. This may end up needing a complex revision with distal femoral mega-prosthesis."

On 6/5/18 at 2:40 P.M., V5/Care Plan Coordinator verified there was not a care plan to address R1's risk for falls.

On 6/6/18 at 9:15 A.M., V8/Physical Therapy Assistant (PTA) verified that she last performed therapy on R1 on 5/7/18 and at that time R1's functional status for transfers were modified independence with an assistive device during transfers; four-wheeled walker.

An attempt to interview V6 and V7/Orthopedic Surgeons was unsuccessful.

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2. R2's Physician Order Sheet, dated June 2018 includes the following diagnoses: Fall with fractured vertebra (2/2/18) and Fall with head injury and fractured vertebra (3/21/18).

R2's Fall Risk Assessment, dated 3/21/18 documents that R2 scored a "20" for fall risks (high risk).

R2's Post Fall Assessment Form, dated 5/9/18 documents, "Observed lying on floor in hallway outside of dining room." This same form documents under Interventions Added, "Call placed to hospice regarding high back char that reclines." No further fall interventions were implemented to prevent further falls.

R2's Post Fall Assessment Form, dated 5/13/18 documents, "Fell asleep in wheel chair and fell out of chair, landing on left side." This same form documents under Interventions Added, "Call placed to hospice again regarding safety intervention as no response from 5/9/18 incident."

On 6/5/18 at 2:42 P.M., V5/Care Plan Coordinator verified that R2's care plan had not been updated to include new interventions to prevent further falls.

3. R3's current Physician Order Sheet, dated June 2018 includes the following diagnosis: Fall with intertrochanteric fracture of left femur (3/25/18).

R3's current Care Plan, dated 3/25/18 includes the following intervention: 2:1 assist with pivot transfers.

On 6/5/18 at 12:50 P.M., V4/Certified Nursing

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S9999	Continued From page 8 Assistant (CNA) prepared to transfer R3 from the wheel chair to bed. V4/CNA applied a gait belt around R3's waist, assisted R3 to stand, pivoted R3, and R3 fell to the bed. At that time, V4/CNA stated, "(R3) is supposed to be a two person transfer." (B)	S9999		