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|---|---|---|---|
| | IL6004212 | A. BUILDING: _____ B. WING _____ | C 12/29/2021 |

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| ILLINI HERITAGE REHAB & HC | 1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821 |

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| S 000 | Initial Comments<br><br>Facility Reported Investigation (FRI) to Incident of 12/15/21/IL141852 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210c)<br>300.1210d)6)<br>300.1220b)2)3)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>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:<br>c)Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br>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:<br>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.<br><br>Section 300.1220 Supervision of Nursing Services<br><br>b)The DON shall supervise and oversee the nursing services of the facility, including:<br>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.<br>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. | S9999 | | |

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| S9999 | Continued From page 2<br>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.<br><br>These Requirements were Not Met evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to complete a thorough fall investigation and implement fall interventions for one (R1) of three residents reviewed for accidents in the sample of three. The facility failed to ensure a floor mat was in place per R1's care plan resulting in R1 sustaining a right pubic rami fracture during a fall.<br><br>Findings include:<br><br>The facility's Fall Prevention policy revised 11/10/18 documents: "5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or AIM (Assess Intervene and Monitor) for Wellness form along with any new interventions deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA (Certified Nursing Assistant) assignment worksheet. 7. Report all falls during the morning Quality | S9999 | | |

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| S9999 | Continued From page 3<br>Assurance meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan."<br><br>R1's Physician's Orders dated 12/18/21-12/31/21 document R1's diagnoses include Functional Quadriplegia, Legally Blind, Osteoporosis, and a history of Left and Right Hip Fractures. R1's Minimum Data Set dated 10/21/21 documents R1 has moderate cognitive impairment, and is dependent on one staff person for bed mobility and at least two staff for transfers.<br><br>R1's Fall Risk Assessment dated 10/19/21 documents a score of 18 indicating R1 is high risk for falling, and R1 uses a full mechanical lift for transfers.<br><br>R1's Care Plan with a start date of 6/18/19 documents: "(R1) has risk factors that require monitoring and intervention to reduce potential for self injury." This care plan documents an intervention dated 8/21/21 to keep R1's bed in low position when R1 is not eating, R1 has had increased confusion. R1's care plan documents an intervention dated 9/21/21 to have a fall mat beside R1's bed.<br><br>R1's AIM for Wellness form documents on 12/14/21 at 4:45 PM R1 was found lying on R1's back on the floor next to R1's bed. R1 hit R1's head and complained of right hip pain.<br>R1 was confused and believed R1 was at R1's family member's house. R1 was transferred to the local hospital. There is no documentation in R1's nursing notes or AIM for Wellness form that R1's bed was in low position, or fall mat was in place at the time of R1's fall. | S9999 | | |

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| S9999 | Continued From page 4<br><br>R1's Medical History and Physical Note dated 12/15/21 at 2:55 AM documents:<br>R1 admitted to the hospital on 12/14/21. R1 fell reaching for a glass of water. R1 hit R1's head, has right leg shortening, and has previous right hip surgery. R1's diagnosis is documented as "fall with acute closed right pubic rami fracture without hematoma". R1's Abdomen/Pelvis CT (Computed Tomography) dated 12/14/21 at 9:40 PM documents: "Acute minimally displaced fractures of the right superior and inferior pubic rami and right parasymphyseal pubis. No associated hematoma."<br><br>The facility's Final Report dated 12/21/21 and signed by V1 Administrator documents: R1 had an unwitnessed fall and was found on the floor of R1's bedroom. R1 told staff that R1 had sat on the edge of R1's bed, attempted to grab a bottle of water, and fell forward from R1's bed. R1 had a bump on R1's forehead and was sent to the local hospital for treatment. The facility was notified R1 had a right pubic ramus fracture. The facility interviewed staff working at the time of R1's fall. V4 and V6 CNAs had assisted R1 to bed prior to the fall.<br><br>V7 Licensed Practical Nurse (LPN) had been in R1's room prior to the fall, gave R1 a bottle of water and a snack, and positioned R1's tray over R1's bed. This report does not document the position of R1's bed or if a floor mat was in place prior to or at the time of R1's fall. The root cause of R1's fall is documented as R1 had an increase in R1's positioning ability. The facility believes R1 pushed R1's overbed tray table away and later attempted to retrieve R1's water. A bed alarm was initiated as R1's fall intervention.<br>There is no documentation in R1's medical record that a bed alarm was implemented subsequent to | S9999 | | |

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| S9999 | Continued From page 5<br>this incident.<br><br>On 12/29/21 at 10:46 AM, R1 was lying in bed and R1's bed did not contain an alarming device. There was a fall mat on the floor beside R1's bed. R1 said, recently had a fall and broke R1's right hip. At the time of R1's fall, R1 had sat R1's self up on the side of the bed to attempt to reach a water bottle that was on an overbed table across R1's room. R1's socks slid across the floor and R1 fell from the bed onto the floor.<br><br>At 11:25 AM, R1 was sitting in R1's wheelchair in R1's room. R1's bed did not contain a bed alarm. R1 stated, "doesn't use a bed alarm. R1 was unsure if the floor mat was a new intervention or if it was in place at the time of R1's fall".<br><br>On 12/29/21 at 1:23 PM, V3 CNA stated: "R1's fall interventions include placing the call light within reach and encouraging to call for assistance. R1 had been having some confusion thinking R1 is working, so educating R1 to use the call light didn't always "stick." R1 never previously tried to sit R1's self up on the side of the bed before, and R1's last fall was about 5 or 6 months ago. R1's fall was unusual in the fact that R1 sat R1's self up on the side of the bed. R1 uses two people for bed mobility and transfers. R1 would use the bed controls to adjust R1's bed height. We had stopped giving the controls to R1 and had been using a floor mat prior to R1's fall.<br><br>On 12/29/21 at 1:46 PM, V5 CNA stated, CNAs do not use a worksheet. Fall interventions are discussed at shift report at the beginning of each shift. V5 was not working at the time of R1's fall but regularly provides care for R1. V5 stated, R1 had been using a fall mat beside R1's bed for the last couple of months. R1 hasn't used any type of | S9999 | | |

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| S9999 | Continued From page 6<br>bed alarm.<br><br>On 12/29/21 at 2:01 PM V4 CNA stated: At the time of R1's fall, V2 and V4 were walking up the hallway. V4 saw R1's overbed table was tipped over and R1 was on the floor. Initially V4 stated, there was a floor mat on the floor. Then V4 stated no, now that I (V4) think about it, I (V4) don't think there was a floor mat in place. I (V4) think that was something that was implemented after R1's fall. V3 and V4 stated, fall interventions are discussed as part of a shift huddle at the beginning of each shift. V3 knows resident fall interventions by looking at the care plan and attending the morning meetings where falls are discussed.<br><br>On 12/29/21 at 10:50 AM, V2 Wound Nurse/Licensed Practical Nurse was asked about R1's 12/14/21 fall. V2 stated: It was close to supper time and V2 and V4 CNA's were coming down the hall and noticed R1's overbed table was tipped over. R1 was lying on the floor with R1's head on a pillow near the foot of R1's bed, and R1's feet near the head of the bed. R1 said, "I was trying to reach my water". V4 and V6 CNAs had been in R1's room about 30 minutes before the fall and had scooted R1 up in bed and given R1 water. V7 LPN had also been in R1's room to give R1 medications and a bottle of water prior to R1's fall. R1 said, R1 was not trying to get out of bed, and R1 had sat R1's self up on the side of the bed. When R1 went to push R1's self back, R1's feet slid on the floor, and R1 was wearing regular socks.<br><br>At 11:29 AM, V2 stated: The new post fall intervention for R1's fall was a floor mat beside the bed. R1 does not use a bed alarm and one was not used after R1's fall. | S9999 | | |

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| S9999 | Continued From page 7<br><br>At 1:34 PM, V2 stated, "at the time of R1's fall, there was not a fall mat on the floor. R1's bed was low to the floor. Falls are discussed in the morning meeting and management is updating the resident care plans with fall interventions. V2 has been assisting since the facility does not currently have a Director of Nursing".<br><br>At 3:00 PM, V2 stated, "staff are expected to look at the resident's care plan to determine fall interventions. Care plans are kept at the nurse's station and available for staff to review. The facility does not use a CNA worksheet to document fall interventions".<br><br>On 12/29/21 at 1:40 PM, V1 Administrator stated: R1's post fall intervention for R1's 12/14/21 fall was to have a bed alarm, but the bed alarm did not work for R1 so we implemented a floor mat. V1 Confirmed R1's care plan documents a fall intervention for the use of a floor mat on 9/21/21.<br><br>On 12/29/21 at 2:10 PM, V1 stated, V1 had no additional documentation to provide for R1's fall investigation or that a bed alarm was implemented after R1's fall on 12/14/21.<br><br>" B " | S9999 | | |