| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004287 | A. BUILDING: _____ B. WING _____ | C 07/25/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HERITAGE HEALTH-MOUNT STERLING | 435 CAMDEN ROAD MOUNT STERLING, IL 62353 |

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| S 000 | Initial Comments<br><br>Investigation of Facility Reported Incident of 07-15-2022/IL149274 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violation:<br>300.610a)<br>300.1210b)<br>300.1210d)6)<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 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. | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br><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><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>These Regulations are not met as evidenced by:<br><br>Based on observation, record review and interview, the facility failed to ensure two qualified staff were present to assist a resident with bed mobility, dressing, transfer and a gait belt was utilized according to facility policy, for one of three residents (R1) reviewed for falls, in a sample of three. These failures resulted V4 (Certified Nursing Assistant) independently dressing R1 and attempting to transfer R1 without a gait belt resulting in R1 falling to the floor sustaining an Acute Displaced Right Distal Femoral Periprosthetic Fracture.<br><br>Findings include:<br><br>The facility policy, titled "Fall Assessment and Management Policy (revised 4/2019)," documents "It is the policy of this facility to assess each resident's fall risk on admission, quarterly, and with each fall. This will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk."<br><br>The facility policy, titled "Safe Resident Handling | S9999 | | |

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| S9999 | Continued From page 2<br><br>Program (revised 3/18/18)," documents "Gait belt usage is mandatory for all resident handling with the exception of mechanical lift use, bed mobility & medical contraindications. The gait belt will be considered a part of the certified nursing assistant's uniform."<br><br>On 7/25/22 at 10:17 am, R1 was sitting in a high back reclining wheelchair on the Memory Unit. R1 did not have the cognitive ability to be interviewed. R1's right leg was in an immobilizer and elevated on the footrest out in front of her.<br><br>The Electronic Medical Record documents R1 has the current diagnoses of Muscle Weakness, Advanced Atrophic No Exudated Macular Degeneration, Anxiety and Dementia without Behavioral Disturbances. Minimum Data Set assessments completed over the last year, on 9/08/21, 12/09/21, 1/11/22, 4/13/22 and 7/14/22, all document R1 requires the extensive physical assistance of two or more staff for bed mobility, dressing and transfers. R1's current Plan of Care, dated 7/14/22, documents "I am at risk for a fall related to confusion, incontinence, poor communication/comprehension" and "TRANSFER: (R1) requires two assist to transfer." A Morse Fall Scale (determines a resident's fall risk), completed on R1 6/05/22, identified R1 as "High Risk for Falling" due to a history of falls, impaired cognition, and overestimating or forgetting her limitations.<br><br>A Report to Illinois Department of Public Health, dated 7/15/2022 at 7:30 am, documents "Nurse called to R1's room observed resident on buttocks on floor at bedside. CNA (Certified Nursing Assistant) reported R1 was sitting on the side of her bed while CNA assisted her with putting her shirt on. R1 scooted quickly toward | S9999 | | |

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| S9999 | Continued From page 3<br><br>the edge of bed and slid down to the floor. R1 complained of pain during initial assessment but was unable to describe exact location of pain. Power of Attorney and Medical Doctor notified, and an order was given to obtain an x-ray in house. While on site on 7/15/22, the x-ray company had technical issues with the mobile x-ray machine and was unable to obtain imaging. On 7/16/22 at 10:44 am, imaging was obtained, and an Acute Displaced Right Distal Femoral Periprosthetic Fracture was discovered. R1 sent to hospital for evaluation and treatment." The Report further documents, "R1 will re-admit 7/19/22 to the skilled nursing unit for skilled therapy close monitoring, and transfer status will be re-evaluated. There is no surgical intervention indicated for the fracture. R1 will be readmitting with full knee immobilizer."<br><br>On 7/25/22 at 12:47 pm, V4 (Certified Nursing Assistant) stated on the morning of 7/15/22, she had gone into R1's room to get her up and dressed for the day. V4 stated V8 (Unit Assistant) was in R1's room at the time and "(R1) is a two person assist, definitely". V4 stated she got R1 dressed and was getting ready to transfer her to her wheelchair. V4 stated R1 did not have a gait belt around her waist at the time. V4 explained that V8 was on one side of R1, and she was on the other, when "R1 just didn't have the strength as we were getting her up." V4 stated "R1 went limp, like dead weight and her legs went out to the side." V4 explained that she used her legs to direct R1's fall, so R1 wouldn't fall forward onto both knees. After the fall, V4 stated she left V8 with R1 and went to the Charge Nurse, V3 (Licensed Practical Nurse), for further assistance.<br><br>On 7/25/22 at 11:40 am, V3 stated she was summoned to R1's room on the morning of | S9999 | | |

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| S9999 | Continued From page 4<br><br>7/15/22, because R1 had fallen. V3 stated, when she walked in R1's room, V8 was on the ground with R1, trying to calm her. V3 stated R1's right knee was swollen, and she described R1 as "uncomfortable." V3 stated two staff are required to assist R1 with ADLs (Activities of Daily Living) and transfers, as R1 can be "unpredictable and make quick movements."<br><br>On 7/25/22 at 1:11 pm, V8 (Unit Assistant) stated 7/15/22 was his first day working as a Unit Assistant in the facility. V8 stated he was in R1's room as V4 got R1 positioned onto the side of the bed and put R1's shirt on. V8 stated he is not allowed to perform direct patient care as a Unit Assistant, so he was just observing V4. V8 stated as V4 was getting ready to transfer R1 from the bed to the wheelchair, R1's "legs just went out from under her" and she fell to the ground. V8 stated he did not participate in assisting to transfer R1, as that is not something he is trained to do, but he was standing off to R1's side as V4 assisted R1. V4 demonstrated with an empty resident bed where he was standing in relation to R1 during the incident, and it was approximately two feet away from her.<br><br>On 7/25/22 at 11:48 am, V1 (Administrator) stated Unit Assistants are not qualified to participate in direct resident care, which includes transfers and dressing. V1 stated a Unit Assistant is not allowed to be the second person to assist in a two-person resident transfer.<br><br>On 7/25/22 at 2:00 pm, V2 (Director of Nursing) stated when she interviewed V4 for her investigation into R1's 7/15/22 fall, it was not fully explained to her that V4 had started to try and transfer R1 when R1 fell. V4 stated, regardless, R1 is a two person assist for dressing, bed | S9999 | | |

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| S9999 | Continued From page 5<br>mobility and transfers, and a Unit Assistant does not count as a second staff person for that type of assistance, because they lack the necessary training. V4 stated a gait belt is always to be used, during any pivot transfer, to ensure resident safety.<br><br>(A) | S9999 | | |