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
	IL6001010	A. BUILDING: ________ B. WING ________	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE BLOOMINGTON	1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701

(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 Investigation of Facility Reported Incident of 7/19/22/IL149619	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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) These Regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement fall prevention interventions according to resident's care plans, and failed to maintain wheelchair equipment in a safe and functional manner to prevent falls. These failures affects two residents (R12 and R14) reviewed for falls. and resulted in R12 experiencing a fracture of the right femur that required surgical repair and a compression fracture of the 12th Thoracic vertebrae. Findings include: 1) The facility's Final Report to Illinois Department of Public Health documents R12 experienced an incident sliding out of the wheelchair, began to show signs and symptoms of increased pain, was sent to the Emergency Room for evaluation and diagnosed with an impacted, angulated fracture of the right femoral neck (type of hip fracture), and a compression fracture of the 12th Thoracic vertebrae (bone in the spine collapses). R12's Medical Diagnoses List documents, "Fracture of Neck of Right Femur" added 7/25/22, and "Fracture of T11 - T12 vertebrae" added 7/23/22. This same Medical Diagnoses List documents historical Diagnoses for R12 including Schizoaffective Disorder, Dementia with Behavioral Disturbance, and Bipolar Disorder.	S9999		

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R12's current Census Detail (8/2/22) documents R12 was in the hospital from 7/19/22 through 7/23/22, returning to the facility 7/23/22.

R12's Hospital Notes dated 7/20/22, 7/21/22, and 7/22/22, document R12 was seen in the emergency room due to a fall at the nursing home, evaluated for injuries utilizing included reports from radiology (x-ray) and computer tomography (CT) scans to determine R12 had experienced an impacted, angulated fracture of the right femoral neck, and a compression fracture of the 12th thoracic vertebrae. These same Hospital Notes document R12 received surgical repair of the femoral fracture, and a back brace to be worn when R12 is up in a chair.
R12's Minimum Data Set dated 7/1/22 documents R12 received a score of 3 on a Brief Interview for Mental Status, rating R12 with severe cognitive impairment.

On 8/2/22 at 11:58 am, V17, Certified Nursing Assistant, stated, "The therapist (V18) said to me that I needed to come because she (R12) is about to fall. I went to the room and (R12) was about half in and half out of the wheelchair on her back with her leg on the bed frame." V17 continued, "(R12's) wheelchair brake on the left side was loose so that when the brake was in the locked position (R12) could still move the chair." At 1:06 pm, V17 clarified, "The brake on (R12's) wheelchair was loose before the fall, like I said, when the brake was locked (R12) could still move the chair. I never did report it to anyone until they (V1 Administrator and V2 Director of Nursing) came down to investigate after the fall and I pointed it out to them. I have been working here for 23 years."

On 8/2/22 at 2:07 pm, V18, Physical Therapist,

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stated, "When I went to (R12's) room to do a therapy session, (R12) was on the floor, supine, flat on her back. (V17) and I got (R12) up to the bed and (V17) changed her clothes because they were wet." V18 continued, "I then did try to do the therapy but (R12) would not stand up from the wheelchair and said her back was hurting."

On 8/2/22 at 3:36 pm, V16, Maintenance Director, stated, "I did put the anti-rollback device on (R12's) wheelchair. At that time the left side brake handle was kind of wiggly, but when I had it in my office, it was holding the chair. No one had reported the loose brake to me until after the fall."

On 8/3/22 at 10:15 am, V19, Certified Nursing Assistant, stated, "I worked with (R12) in the days and weeks before she fell. I had noticed her wheelchair brake was loose and wiggly and she could move the wheelchair even when it was locked. I didn't report it to maintenance because I never put the wheelchairs in the locked position." V19 continued, "I know there is a board over there to put in maintenance orders."

2) R14's current Care Plan (8/3/22) documents fall prevention interventions for anti-rollback bar to be placed on (R14's) wheelchair, initiated 10/17/19. This same Care Plan documents for (R14) to have non-skid strips placed on the floor beside the bed, initiated 4/14/20.

On 8/3/22 at 10:00 am, R14 was seated on the edge of the bed dressing her lower half with pants. R14 at the time, was wearing only regular cotton socks on her feet and had tennis shoes by her feet which R14 had not yet placed on her feet. R14 had to rise to a standing position in order to place her pants on. There were no non-skid strips on the floor by the bed. R14's wheelchair was

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S9999	Continued From page 4 directly next to R14 at the bedside. This wheelchair did not have the anti-rollback device installed. On 8/3/22 at 10:10 am, R14 was in the aforementioned wheelchair rolling independently into the hallway. At this time, V2, Director of Nursing, accompanied (surveyor) into R14's room and confirmed there were no non-skid strips on the floor by stating, "No, I don't see them, I think (R14) had a room change." V2 then confirmed there was not an anti-rollback device on R14's wheelchair, stating, "That is not even (R14's) wheelchair. The wheelchair did have a label on it with a name that was not R14's name. V2 then clarified, "That resident doesn't even live here anymore." On 8/3/22 at 10:15 am, a general tour of the locked dementia care unit where R14 resides determined there was only one wheelchair on the unit with the anti-rollback device installed and that wheelchair belonged to R12 who had the anti-rollback device installed between 7/19/22 and 7/23/22. On 8/3/22 at 11:20 am, V1, Administrator, stated, "Regardless if (R14) had a room change or not, we didn't we didn't move the (non-skid) strips with her, and that isn't her wheelchair but there isn't an anti-rollback device on it." (A)	S9999		