STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008510	A. BUILDING: _____ B. WING _____	C 05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

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S 000	Initial Comments FRI of 5/4/2022\IL146968	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.12010c) 300.1210d)6 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 resident to meet the total nursing and personal	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. These Requirements wer NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to document thorough investigations to determine the root cause of falls. The facility also failed to ensure residents were protected from injury and the potential for injury during transport. This failure affects two of three residents (R1, R2) reviewed for falls in the sample of five residents. This failure resulted in R1 falling forward from R1's wheelchair while being transported. R1 sustained a 2 centimeter laceration to R1's left forehead which required emergency room intervention. Findings include: 1. R1's Minimum Data Set (MDS) dated 2/17/22 documents R1 requires extensive assistance of one/limited assistance of one for mobility on and off unit. This MDS also documents R1 is	S9999		

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S9999	Continued From page 2 cognitively intact. R1's fall investigation for R1's fall on 5/4/22 documents the following: The Final Report sent to the State Survey Agency on 5/10/22 at 4:18pm documents R1 had fallen out of the wheelchair while being transported by V3, Certified Nursing Assistant (CNA.) This report documents R1 had bleeding from the left side of R1's head and went to the emergency room and received three sutures above the left eye. This report also documents while being transferred in the wheelchair, R1's "foot dropped onto the floor causing (R1) to fall forward from the wheelchair." Intervention is for R1 to have foot pedals on while being transported by staff in the facility. There is no documentation in this fall investigation as to why R1's foot dropped. There is no documentation that the wheelchair was evaluated after the fall. There is no documentation the use of leg rests/foot pedals in place/in use during the transport via wheelchair. R1 and V3's witness statements do not document the use of leg rests/foot pedals. R1's Emergency Room records dated 5/4/22 document R1 reported R1 was being pushed by a staff member at the facility and R1 put R1's "foot" down to rest on the pedals but there "was not a pedal down" and R1 fell out. These records document Computed Tomography (CT) of the brain results documenting R1 has a left frontal scalp subgaleal hematoma (bruise.) These records also document R1 had a 2 centimeter round laceration with avulsion of skin to R1's left forehead and bruising to R1's right knee and left shoulder.	S9999		

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S9999	Continued From page 3 R1's Physician's Orders dated 4/29/22 document an order for Physical Therapy and Occupational Therapy to evaluate and treat. R1's Physical Therapy (PT) Evaluation dated 5/4/22 at 1:53pm documents the reason for the referral to PT is due to ongoing decline in function and increased need for caregiver assistance. This evaluation also documents R1 is "very stiff" in both lower extremities and trunk. On 5/16/22 at 1:45pm, R1 stated V3, Certified Nursing Assistant (CNA) was pushing R1's wheelchair (on 5/4/22) after R1 had went to the restroom. R1 stated R1's foot rests were not on R1's wheelchair or the pedals were not down. R1 stated R1 can only hold R1's feet up/legs up for so long before R1 needs to rest them. R1 stated R1 uses the foot pedals frequently to assist with R1's legs when they get tired and thought V3 had put the foot pedals down. R1 stated R1 had moved R1's legs/feet down to rest them on foot pedals, but the foot pedals were not down and that is when R1 fell forward out of the wheelchair. R1 stated R1 has to use the foot pedals due to weakness in both R1's legs. On 5/17/22 at 1:10pm, V1, Administrator stated R1 stated R1 was holding R1's feet up but R1's right leg dropped. V1 stated R1 did not say why the right leg dropped and V1 did not ask about potential reasons causing R1's leg to drop. V1 stated V1 did not think there were foot pedals on R1's wheelchair at the time of the fall. V1 stated R1 did not tell V1 anything about foot pedals not being there and V1 did not ask details about the wheelchair or why R1's leg dropped. V1 stated V1 did not take a look at R1's wheelchair after R1's fall from the wheelchair.	S9999		

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S9999	Continued From page 4 2. R2's Care Plans dated 12/30/21 document R2 requires physical assistance with gait belt and walker for ambulation. R2's Fall Investigations document as follows: On 3/16/22 at 5:45am, R2 fell in R2's room while ambulating. This note documents no injuries were noted. Bed was not in low position and nursing staff states that R2 will raise R2's bed to standard height on R2's own and self transfer. Intervention: remove fall mat as R2 will get in and out of bed per staff. R2 stated, "(R2) slipped on that damn thing" pointing to the fall mat next to R2's bed. This note documents R2 tripped on the floor mat attempting to self transfer. This note documents the root cause of the fall as mat in way of ambulation and intervention of non-skid strips on floor. There is no documentation in this investigation as to what R2 was attempting to do or why R2 got up on R2's own. There is no documentation as to which staff stated R2 raises R2's bed on R2's own. There is no documentation of multiple staff interviews. On 4/13/22 at 9:16am an unidentified CNA walked past R2's room and observed R2 laying on R2's left side on the floor holding R2's head in front of R2's chair. R2 was wearing shoes and a robe. R2 stated R2 was cold so R2 got up and went to bedroom to put a robe on. R2 stated R2 lost R2's balance and fell. Fall intervention- sign placed on walker that documents to remember to use R2's walker at all times. This note documents there were no witnesses. Conclusion: observed on the floor. Root Cause: didn't use R2's walker. Intervention: sign placed on walker to remind R2.	S9999		

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S9999	Continued From page 5 There is no documentation as to R2's location prior to the fall. This investigation documents the walker was by the bedside table, but there is no documentation as to R2's location prior to the fall in relation to the walker. There is no documentation in to investigating why R2 was cold/temperature in R2's room. This investigation does not document additional witness statements from multiple staff who provided care for R2. On 5/17/22 at 2:30pm, V2, DON confirmed there were no additional witness statements related to R2's fall on 4/13/22. V2 stated the investigation does not document investigation in to multiple details of R2's fall. R2's Fall Investigation (5/7/22 at 1:35am per Progress Note) documents: The facility's final report to the State Survey Agency on 5/11/22 at 3:24pm documents R2 was assessed by staff and had bleeding to the left side of R2's head. This report documents R2's roommate (R4) stated R2 was standing near the foot of (R4's) bed, turned to (R2's) own bed, stumbled and fell onto the floor. R2 did not have R2's walker during ambulation. R2 was sent to the emergency room and found to have a left hip fracture. There is no documentation as to where R2 was found on the floor or how R2 was positioned when R2 was found on the floor. There is no root cause of this fall documented. On 5/17/22 at 1:10pm, V1, Administrator stated V8, CNA stated R2's roommate (R4) called for help. V8 stated V8 did hourly checks on R2 and R2 was in the bed about an hour before when V8 "peeked" in on R2. R2's roommate had turned on	S9999		

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S9999	Continued From page 6 the call light and that is when V8 found R2 on the floor. I don't recall staff mentioning if they had asked what R2 was trying to do or why R2 had gotten up on R2's own. The Root Cause: "the only thing we got was he fell by R2's bed." Roommate did not say. V1 stated V1 did not ask about R2's walker location and R4 did not say what R2 was trying to do when R2 fell. The facility's Fall Assessment and Management Policy dated April 2019 documents the facility is to assess each resident's fall risk with each fall to help facilitate an interdisciplinary approach for care planning to appropriately monitor assess and ultimately reduce injury risk. The potential for falls will be care planned when appropriate based on the fall assessments. The interdisciplinary care plan will be person centered to reflect the specific needs and risk factors of the resident. Assessment parameters include a description of how the resident was observed and circumstances surrounding the fall. (B)	S9999		