

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6004212	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/11/2022
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NAME OF PROVIDER OR SUPPLIER  ILLINI HERITAGE REHAB & HC	STREET ADDRESS, CITY, STATE, ZIP CODE 1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821
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S 000	Initial Comments  Investigation of Facility Reported Incident of 5/24/22 IL#147869	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.1210b) 300.1210c) 300.1210d)6)  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.  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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
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S9999	<p>Continued From page 1</p> <p>that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview and record review the facility failed to provide supervision and implement fall interventions for one of three residents (R1) reviewed for falls in the sample of six. This failure resulted in R1 falling out of bed and sustaining a fracture of the right upper extremity.</p> <p>Findings include:</p> <p>R1's Physician Order Sheet dated June 2022 documents R1 is diagnosed with Muscle Spasms, Congestive Heart Failure, Anxiety, Atrial Fibrillation, Dyspnea, Morbid Obesity, Functional Quadriplegia, Osteoporosis, and is Legally Blind. R1 is prescribed the anticoagulant Eliquis 2.5 milligrams twice daily for Atrial Fibrillation.</p> <p>R1's Fall Risk Assessment dated 3/21/22 documents R1 is at High Risk for falls in part due to R1's altered mental status, R1's need for assistance with elimination, R1's use of assistive devices for transfer, R1's medications, and R1's impaired hearing, joint pain, and previous fractures.</p> <p>R1's Minimum Data Set dated 3/24/22 documents R1 is severely cognitively impaired and she is totally dependant of at least two staff for transfers.</p> <p>The Incident Investigation Form dated 5/24/22 documents on 5/24/22 R1 was found on the floor beside her bed. R1 complained of pain and was sent to the Emergency Room for further evaluation.</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>R1's Diagnostic Computed Tomography Report of the Right Humerus dated 5/24/22 documents R1 sustained an acute fracture of the distal Humerus related to acute trauma (fall).</p> <p>On 7/11/22 at 2:20 PM V6 Licensed Practical Nurse stated around midnight on 5/24/22, R1 was found by V6 and V9 Certified Nurses Assistant. R1 had rolled out of bed and was lying on the floor beside her bed. V6 stated the bed was not in the low position and there was no fall mat under R1 or beside her bed. V6 confirmed R1 was a high fall risk and should have been in a low bed and should have had a fall mat beside her bed.</p> <p>On 7/11/22 at 3:09 PM V9 Certified Nurses Assistant stated she found R1 on the floor by her bed around midnight on 5/24/22. V9 stated R1 is a high fall risk and can be confused. V9 stated R1 was supposed to have a fall mat by her bed but it was not there at the time of her fall. V9 stated R1 should've also been a low bed however her old bed broke and she was moved to a different bed that could not be lowered all the way down. V9 confirmed when R1 fell out of bed on 5/24/22, R1's bed was not in the low position.</p> <p>On 7/11/22 at 3:30 PM V1 Administrator confirmed R1 is a high fall risk, has altered mental status, is on an anticoagulant, and requires assistance for transfers and mobility. V1 confirmed that prior to R1's fall on 5/24/22, R1 was moved to a new bed because her bed no longer worked. V1 stated the bed that R1 was moved to was an older bed and it could not be lowered down to the floor. V1 confirmed R1 should be in a low bed and should have a fall mat by her bed. V1 confirmed its possible that if R1 would've rolled out of a low bed onto a fall mat,</p>	S9999		

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S9999	Continued From page 3  she might not have sustained a fracture. V1 confirmed both of those fall interventions should have been in place at the time of R1's fall on 5/24/22.  <p style="text-align: right;">(A)</p>	S9999		