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
	IL6000996	A. BUILDING: ______ B. WING ______	C 10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMINGTON REHABILITATION & HCC	1925 SOUTH MAIN 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 Facility Reported Incicdent of September 20, 2023 IL165188	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)6) 300.1220 b)3) 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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 care needs of the resident. 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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. 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. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a call light in operable condition, resulting in a resident (R4) fall from bed; failed to identify an intervention post-fall for (R4); and failed to maintain a metal bed frame, free of sharp edges (R3); and failed to	S9999		

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implement a post-fall intervention (R3). These failures resulted in R3 sustaining a deep laceration during an improper transfer, that required nine sutures and 18 staples to close the wound. These failures affected two of three residents (R3 and R4) reviewed for fall/accidents on the sample list of 21.

Findings include:

1. R3's Physician Order Sheet (POS), dated 10/01/23-10/31/23, documents the following diagnoses: Diabetes Mellitus Type II, Coronary Artery Disease, Chronic Kidney Disease, Deep Vein Thrombosis, Obesity, Frequent Falls. The same POS document R3 medications include Coumadin (blood thinner) 2.5. milligrams by ,mouth every Thursday and 5 milligrams Sunday through Wednesday and Friday and Saturday.

R3's Minimum Data Sheet (MDS) documents R3 Brief Interview of Mental Status score of 15 out of a possible 15, indicating R3 has no cognitive impairment.

R3's Care Plan, updated 9/21/23, documents the following post-fall intervention: "PT (Physical Therapy) to provide training on safe transfers. (full mechanical lift) transferring (sic) until resident able to transfer with assistance and no (mechanical lift)."

The facility "Fax (Facsimile) Worksheet IDPH (Illinois Department of Public Health)", dated as occurred 9/20/21 at 8:00 pm (hospital records document 9/19/23) documents R3 sustained a laceration to the lower right leg while she was being assisted with transferring from her bed to the wheelchair (wheelchair to bed per witness interviews). The same Fax worksheet documents

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R3 went out to the hospital and returned with sutures present and oral antibiotics therapy.

R3's local hospital Emergency Department, dated 9/19/23, discharge records document R3 was treated as follows: Laceration Repair: Right lower leg, 25 centimeter long, required nine sutures and 18 staples for closure of the the laceration.

On 10/18/23 at 5:50 pm, R3 was seated in her wheelchair. R3 stated there were three people transferring R3 on 9/19/23 when she almost fell. R3 stated, "Two brand new CNA's (Certified Nursing Assistants) and a nurse (unidentified) were transferring me. They tried to lift me up from my chair (wheelchair) to put me to bed. My bed was on the other side (door side) of the room at that time. The bed had exposed metal (exposed chipped metal post on the bed frame)that I cut my leg on. They have since moved my bed to this other wall (window side). The side I get into now has these plastic caps over the metal, like the other side should have too. They haven't found the plastic caps to cover those others (exposed chipped metal post on the bed frame), still. My gait belt was loose. I told them it needed tightened. They did not tighten it. They ignored me. I also told them (staff) in therapy they wanted me to use my walker to stand. I told them I was way to far from the bed. I was about three feet away from the bed. I don't walk. I can't walk. I am supposed to stand and pivot. You can't pivot three feet away from a chair to a bed. I am a nurse. That is not a pivot transfer. Only one of the CNA's had a good hold on me. She was behind me hanging onto my gait belt. They did not listen to me and expected me to walk. Both my legs went out from under me as they fumbled around to push me all the way into bed. My legs slid under the bed. It was with a lot of force they had to push

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me, to get me across three feet to my bed. My leg was bleeding pretty bad. I am on blood thinner. I knew the cut was bad. I got 18 staples and nine stitches to close it (right leg laceration). It was two and a half inches deep. They did not know what they were doing and that was obvious. They need to be trained properly and need to listen to what a person says. Sometimes I am right. This could have been prevented had any one of them listened."

On 10/18/23 at 6:15 pm, V6, Certified Nursing Assistant (CNA) entered R3's room. R3 adjusted R3's wheelchair and positioned her wheelchair away from the bed. V6, CNA, moved R3's bed away from the windowed wall. V6, CNA, confirmed the window wall-side of R3's bed frame had two missing plastic covers that exposed two square shaped, metal, bed brace bar. The exposed metal bars were chipped and located at the at the distal end of the middle section of the bed frame. R3 repeated, "That is why they moved my bed from the door side wall to the window side wall." V6 confirmed R3's bed was on the other wall prior to R3's leg injury. V6 was not aware as to why the bed was moved to the other wall . V6 stated, "It makes sense though. Nobody can get hurt on that side of the bed, again."

On 10/20/23 at 9:13 am, V16, Director of Rehab/ Physical Therapy Assistant, stated, "(R3) has a jagged cut. A jagged (laceration) L shaped that is crossed like a jagged T. She should a have never been three feet from the bed when transferred. She was supposed to be a pivot transfer, assist of two, I was working with her prior to the fall. She was a two assist, gait belt and walker. As therapy was only working with (R3) to stand with a walker. She could not walk. We were working on standing strength to build her endurance. When I talked to

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S9999	Continued From page 5 (R3) after her fall, she showed me in her room where the staff were standing. It (the distance R16 observed) was three feet away from the bed, when she (R3) gave me the details of the fall. I find (R3) to be totally in tune and has had no cognizant issues, follows directions well. (R3) told me she clearly relayed to the staff that her gait belt was too loose and she was suppose to use her walker and pivot (turn upon rising from the wheelchair) closer to her bed. In morning meeting that next day, I was told we would be educating staff on use of the gait belt and positioning during pivot transfers. I told them (administration staff) in that same meeting to tell me when they can get the CNA's (Certified Nursing Assistants) in the building, and I will get it (training) done. I asked the Administrator a couple times after that, when she could arrange for this staff education, so I could add it to my schedule. I did no education on resident transfers for the CNA's, after we talked about it in morning meeting." On 10/24/23 at 7:20 am, V11, Agency Licensed Practical Nurse, stated, "In regards to (R3's) laceration to her right calf, I was the nurse; I went to assist with (R3's) transfer from the wheelchair to the bed. A gait belt was placed by (V32, Certified Nursing Assistant/CNA) and (V30, CNA). I don't remember if (R3) said anything about the gait belt being loose. She may have. (R30) moved the wheelchair when we (V11 and V32) assisted (R3) to stand up. (V32, CNA) was in front of (R3), and I was at the side. We transferred (R3) to bed. I don't know if she cut her leg on the wheelchair pedal bar or the bed frame. The wheelchair pedal were still on her (R3)wheelchair and just turned outward. I don't know if there was exposed rough metal on the bed. I addressed the resident needs and called 911 immediately."	S9999		

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S9999	Continued From page 6 On 10/24/23 at 10:42 am, V32, Certified Nursing Assistant (CNA), stated the following: "(R3) wanted to go to bed. I did not know her (R3) and did not know how she (R3) transferred. She is pretty big and heavy (stature). I am really small. I went to get the other CNA (V30). I am new and this was the first time I transferred her (R3). (V30) did not know how she (R3) was supposed to be transferred either. (V30) is really small too. I went to get the nurse (V11, Agency, Licensed Practical Nurse) for help (to transfer). I was in front of (R3's) wheelchair. (V30, CNA) was behind the wheelchair, and the nurse (V11, LPN) was off to (R3's) side. We put the gait belt on. I did not realize it was kind of loose until we started to get her up out of the chair (wheelchair). Then it was too late. We were trying to get her (R3) over to the bed, and her legs slid under the bed. Her upper body was on the bed. I raised her legs up to put them in the bed. There was a ton of blood in a puddle on the floor. I saw the bed frame had a sharp areas and guessed that is what caused her injury. I told the nurse to call 911 because I could see it was way more then a skin tear. It was really deep and bleeding heavy. She (R3) needed to go to the hospital for sure. We put a towel on her leg and held pressure on it until the ambulance came. I know the bed caused her (R3) injury (25 centimeter laceration), and she was too heavy. I couldn't support her body weight to transfer. She probably should have been a (mechanical lift transfer). There has not been anybody tell me to go to get instructions from physical therapy for transferring resident. The Director of Nursing (V2) and Nurses haven't said anything either. We use the (mechanical lift) to transfer her (R3) now. It is sad she had to get hurt before we were told to use a (mechanical lift) for her transfers."	S9999		

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On 10/24/23 at 1:35 pm, V1, Administrator, entered R3's room and assessed R3's bed frame . V1 stated, " I found a bunch of these plastic covers (points to several metal bed frame bars that were covered with plastic protective caps) . We need to get some on these two post (bed frame bars) They have obvious chips in the metal. I did not realize that until now. It makes sense as to why somebody moved her (R3's) bed up to the window (from the door side of the room). Obviously, it was to conceal the chipped metal. I only inspected the bed after it had been moved."

On 10/24/23 at 1:55 pm,V2, Director of Nursing, reviewed falls R1, R3 and R4. V2, DON stated she had no idea R3's bed had chipped metal. V1, Administrator, was present and confirmed she had confirmed R3's bed had chipped metal bed on the frame.
V2 acknowledged the CNA's have not been re-trained by therapy on safe transfers as R3's care plan intervention documents. V2 also acknowledged gait belt should be snug around the resident's waist to prevent it from raising up and promote safety during transfers.

2. R4's Physician Order Sheet (POS), dated 10/1/23-10/31/23, documents a diagnoses of Parkinson's (disorder of the central nervous system that often includes tremors).

R4's Minimum Data Set (MDS), dated 8/16/2,3 documents R4' Brief Interview of Mental Status score of 11 out of 15, indicating moderate cognitive impairment. The same MDS documents R4 has functional limitations in range of motion in bilateral upper and lower extremities and is totally dependant on staff for transfers.

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S9999	Continued From page 8 R4's Care Plan, updated 8/24/23, with no updates since that review. There are has no targeted intervention documented for R4's fall 9/10/23. R4's Fall Risk Assessment, dated 8/23/23, documents R4 was at high risk for falls. R4's fall risk score was 21. The same assessment documents a score greater then 10 equals high risk. R4's Nurses Notes, dated 9/10/23, document R4 fell and sent to the emergency room. R4's Hospital "After Visit Summary", dated 9/10/23, document R4 had a fall that resulted in a Closed Head Injury. On 10/18/23 at 5:10 pm, R4 was partially reclined in specialty wheelchair. R4 stated her call light does not work. She has asked multiple staff to get the call light fixed and it is still not fixed. R4 stated, "It (call light) was broken for a while before the fall that sent me to the hospital (9/10/23). I tried to put my call light on a couple weeks ago (9/10/23), while in bed, the light still didn't work. I (R4) wanted to get up in my wheelchair to get more comfortable than when I was in bed. I (R4) fell out of bed, hit my head and hip. I had to go to the hospital because I was in so much pain." On 10/24/23 at 11:20 am, R21, R4's roommate, stated, "I put the call light on for (R4) the night she fell out of bed. (R4's) call light had been broken for over a month before that fall (9/10/23). I had been turning mine on every time she (R4) asked me too. (R4) had told a couple CNA's (unidentified, Certified Nursing Assistants) weeks before her fall, that she needed the call light fixed. They (unidentified CNA's) would say they would	S9999		

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turn in a work order. I think (V29, CNA) put one (work order) in after (R4) fell. It still did not get fixed until last week. Maintenance must be very busy."

On 10/24/23 at 11:34 am, V29, CNA, stated, "I am pretty sure I put a work order in to get (R4's) call light fixed about a month ago, I think. It (call light cord) did not have a button to push. It was just a hole at the end of the cord. (R4) told me she had asked other staff (unidentified) to get maintenance to fix it. It had not been fixed. We put work orders in the maintenance door cubby thing, on the Dogwood (unit)."

On 10/24/23 at 1:35 pm, V1, Administrator, stated, "(V1 and V18, Social Service Director) have been doing the little maintenance task. The facility no longer has in-house maintenance staff. (V18, SSD) replaced R4's call light last week. She (R3) will get the plastic caps on the (R3's) bed today. (V33) is Regional Maintenance, he will come in (to the facility) if needed for bigger issues. I found a work order, dated 9/29/23, for (R4's) call light to be replaced."

On 10/24/23 at 1:45 pm, stated V1, Administrator, provided the following work order:
"Maintenance Work Order", dated 9/29/23, (identified R4's room by number, bed A), "by the door needs a call light."

The facility "Fall Prevention" policy, dated as revised 11/10/2018, documents the following:
"Policy:
To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility.

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S9999	Continued From page 10 Responsibility: All staff." The same policy documents includes the following guidance for staff: Procedure: 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. (B)	S9999		